

Medical Fieldcraft

A Graphic Reference Guide





The content of this guide was compiled from military publications and information from:

- **Centers for Disease Control & Prevention**
- **Defense Health Agency**
- **International Federation of Red Cross and Red Crescent Societies (IFRC)**
- **Johanniter International**
- **National Institutes of Health**
- **National Library of Medicine**
- **PNW Street Medics**
- **Prolonged Field Care Collective**
- **Substance Abuse and Mental Health Services Administration**
- **Wilderness Medical Society**
- **World Health Organization (WHO)**

D

- DANGER

R

- RESPONSIVE?

S

- STOP SEVERE BLEEDING
- SUMMON/SEND FOR HELP

A

- AIRWAY

B

- BREATHING

C

- CPR²/CIRCULATION

D

- DEFIBRILLATION/DISABILITY

Performing CPR

Providing chest compressions

Performing chest compressions is tiring and ideally the provider should be changed every 2 minutes. CPR should only be stopped if the patient starts to show signs of life, when further medical help arrives, or the provider becomes exhausted.



► Figure 7 - Chest compressions

- Move the patient onto their back laid on a firm surface and kneel beside their chest
- Place the heels of both hands on the centre of the chest with your arms straight with one hand upon the other (Figure 7)
- Give 30 chest compressions aiming to achieve a rate of 100-120 compressions/minute
- For each compression firmly press down by 5-6cm, fully releasing the pressure between compressions without your hands leaving the chest (Figure 7)

Providing rescue breaths



► Figure 8 - Head tilt-chin lift



► Figure 9 - Rescue breath

- The ratio of chest compressions to breaths should be 30:2
- Lift the chin and tilt the head back (Figure 8)
- A face shield or face mask will make the delivery of breaths safer and more acceptable for the first aider
- Place your mouth around the patient's mouth, ensuring you have a good seal and pinch their nose (Figure 9)
- Attempt to deliver only 2 breaths of about 1 second duration each time making the chest visibly rise
- If unsuccessful in delivering breaths re-check the airway on the next attempt for a visible blockage (and remove it if present) and reposition the patient's head

If you are unwilling or unable to give breaths, then you should **deliver only chest compressions**. In most countries the emergency services operator will provide instructions for resuscitation which should be followed to the best of your ability.

CPR SUMMARY

	Hand Position	Compress	Breathe	Cycle	Compression Rate
Adult 	Two hands on the middle of the chest	At least 5 cm (about 2 in.)	Just enough volume to make the chest start to rise (1 second per breath)	30 compressions and 2 breaths	Rate of 100–120 per minute: 30 compressions in about 15–18 seconds.
Child 	Two hands on the middle of the chest	At least 1/3 of the chest's depth	Just enough volume to make the chest start to rise (1 second per breath)	30 compressions and 2 breaths	Rate of 100–120 per minute: 30 compressions in about 15–18 seconds.
Baby 	Two fingers on the middle of the chest (just below the nipple line)	At least 1/3 of the chest's depth	Gently, with just enough volume to make the chest start to rise (1 second per breath)	30 compressions and 2 breaths	Rate of 100–120 per minute: 30 compressions in about 15–18 seconds.

Tactical Combat Casualty Care

Evaluation of a casualty is necessary to identify and treat all life-threatening conditions and other serious wounds. Rapid and accurate evaluation of the casualty is the key to providing effective first aid.

Use **MARCH** as the inspection process for the proper order of treatment and **PAWS** for additional casualty care issues:

<u>M</u> assive Hemorrhage	<u>P</u> ain
<u>A</u> irway	<u>A</u> ntibiotics
<u>R</u> espirations	<u>W</u> ounds
<u>C</u> irculation	<u>S</u> plinting
<u>H</u> ead Injury / Hypothermia	

Tactical Combat Casualty Care (TC3) can be divided into three phases:

Care under fire, Tactical field care, and Tactical evacuation care.

Care under fire limits the care you can provide:

- Return fire as directed or required before providing medical treatment.
- Determine if the casualty is alive or dead.
- Provide tactical care to the live casualty.
- Administer life-saving hemorrhage control.
- Transport the casualty, his/her weapon, and mission-essential equipment when the tactical situation permits.
- Re-check bleeding control measures as the tactical situation permits.

Tactical field care occurs when you and the casualty are relatively safe and no longer under effective hostile fire.

- Form a general impression of the casualty as you approach (extent of injuries, chance of survival).
- Check for responsiveness.
- Position the casualty and open the airway
- Assess for breathing and chest injuries.
- Identify and control breathing.
- Check for fractures.
- Check for burns.
- Administer pain medications and antibiotics (the casualty's combat pill pack) to any Soldier wounded in combat.
- Transport the casualty to the site where evacuation is anticipated.
- Document injuries on the casualty's TC3 card.

Tactical evacuation care is rendered during casualty evacuation (CASEVAC):

- Care is rendered while the casualty is awaiting pickup or is being transported.
- A Soldier accompanying an unconscious casualty should monitor the casualty's airway, breathing, and bleeding.

RAPID CASUALTY ASSESSMENT

01



ASSESS scene safety

including sources of burning, electrocution, or enemy threat

02



ASSESS the casualty for responsiveness

03



RETRIEVE first aid kit

04

M

MASSIVE BLEEDING

STOP life-threatening bleeding

A

AIRWAY

MAINTAIN an open airway

R

RESPIRATION

ASSESS respiration and breathing **LOOK, LISTEN AND FEEL!**

C

CIRCULATION

MONITOR casualty's blood circulation and prevent shock

H

HYPOTHERMIA

PREVENT hypothermia by keeping the casualty warm and dry

05



CHECK for other injuries

including eye trauma, head injury, burns, or fractures

06



DOCUMENT medical aid on a DD1380 TCCC Card

07



COMMUNICATE with medical personnel any aid provided

COMBAT APPLICATION TOURNIQUET (CAT)



REMOVE CAT tourniquet from the first aid kit or carrying pouch



SLIDE the injured arm or leg through the loop of the self-adhering band



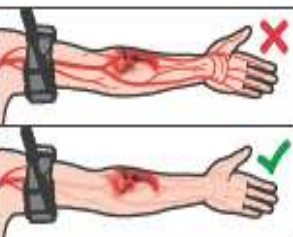
POSITION self-adhering band at least 2-3 inches above the wound site



PULL the free end of the band as tightly as possible around the extremity



TWIST the windlass rod to tighten the self-adhering band until the bleeding has stopped



APPLY tourniquet to stop bleeding within 1 minute



LOCK the windlass rod inside either clip to secure it



ROUTE the self-adhering band between the clips and around the rod



SECURE windlass rod and self-adhering band under the windlass safety strap



WRITE the time of tourniquet application on the safety strap and on a DD1380 TCCC Card or forehead



COMMUNICATE with medical personnel any aid provided

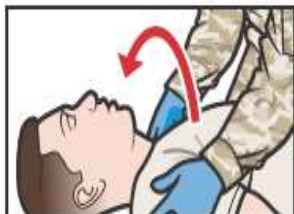
HEAD-TILT/CHIN-LIFT

NOTE: DO NOT use if a spinal or neck injury is suspected.



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



- 01** ROLL the casualty onto their back, if necessary, and PLACE them on a hard, flat surface.



- 02** KNEEL at the level of the casualty's shoulders. POSITION yourself at the casualty's side.



- 03** OPEN mouth and LOOK for visible airway obstructions (e.g., lacerations, obstructions, broken teeth, burns, or swelling or other debris, such as vomit).
NOTE: If foreign material or vomit is in mouth, remove as quickly as possible.
NOTE: NO blind finger sweeps.



- 04** PLACE one hand on casualty's forehead. APPLY firm, backward pressure with the palm to tilt the head back.



- 05** PLACE fingertips of other hand under the bony part of lower jaw and lift, bringing the chin forward.
NOTE: Do not use thumb to lift the chin.



- 06** While maintaining the open airway, PLACE ear over mouth and nose, looking toward chest and stomach.



- 07** LOOK for the chest to rise and fall.



- 08** LISTEN for air escaping during exhalation.



- 09** FEEL for the flow of air on the side of your face.



- 10** MEASURE the respiratory rate.



- 11** DOCUMENT all findings and treatments on the DD Form 1380 TCCC Casualty Card and attach it to the casualty.

JAW-THRUST MANEUVER



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.

NOTE: Use this technique when neck/spine injury is suspected.

CAUTION: Neck and/or spine injuries are suspected in obvious head or neck trauma and in blast injuries or motor vehicle accidents.



01 ROLL the casualty onto their back, if necessary, and place them on a hard, flat surface.



02 KNEEL above the casualty's head (looking toward the casualty's feet).



03 OPEN mouth and LOOK for visible airway obstructions (e.g., lacerations, obstructions, broken teeth, burns, or swelling or other debris, such as vomit).

STEP 3 NOTE: If foreign material or vomit is in mouth, remove as quickly as possible. **STEP 3 NOTE:** NO blind finger sweeps.



04 REST your elbows on the ground or floor.

05 PLACE one hand on each side of the casualty's lower jaw at the angle of the jaw, below the ears.

06 STABILIZE casualty's head with your forearms. **NOTE:** DO NOT tilt or rotate the casualty's head.



07 Using index fingers, PULL jaw up while using thumbs to PUSH casualty's chin forward.

NOTE: If casualty's lips are still closed after jaw has been moved forward, use your thumbs to retract lower lip and allow air to enter the casualty's mouth.



08 Keeping airway open, PLACE ear over mouth and nose, looking toward chest and stomach.



09 LOOK for the chest to rise and fall.



10 LISTEN for air escaping during exhalation.

STEP 8 NOTE: Avoid gross manipulation of the head and neck if tactically feasible. A second rescuer may be needed to maintain the jaw-thrust maneuver (if time and tactics dictate) as the primary rescuer continues to assess and treat the casualty.



11 FEEL for the flow of air on the side of your face.



12 MEASURE the respiratory rate.



13 DOCUMENT all findings and treatments on the DD Form 1380 TCCC Casualty Card and attach it to the casualty.

PRESSURE BANDAGE APPLICATION



REMOVE the bandage from the pouch and packaging



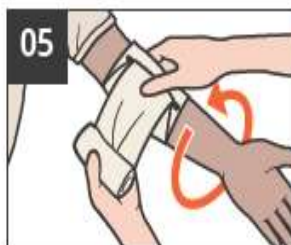
PLACE the pad directly on the wound and maintain pressure



WRAP the elastic bandage around injured extremity and maintain pressure



INSERT the elastic bandage into the pressure bar



REVERSE WRAP the elastic bandage back over the top of the pressure bar



WRAP bandage tightly over the pressure bar until pad edges are covered



SECURE the hooking end of the pressure bar into the elastic bandage



ASSESS circulation below bandage to ensure a pulse; loosen, if needed



DOCUMENT medical aid on a DD1380 TCCC Card



COMMUNICATE with medical personnel any aid provided

IMPALED OBJECT



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



01
GENTLY expose the impaled object by cutting or removing clothing to expose the wound site.



02
If the impaled object is **PROTRUDING** from an extremity, check the pulse distal to the wound to determine if circulation is impaired.

NOTE: If circulation is impaired, prioritize the casualty for evacuation.



03
ASSESS wound, and if serious bleeding present, apply direct pressure to control bleeding, ensuring not to apply pressure to the impaled object.

NOTE: Reassess tourniquet, if applicable.



04
DIRECT the CLS or another first responder to manually stabilize the impaled object while you dress the wound.

NOTE: As an alternate method of stabilization, secure using a chest seal.



05
APPLY a dressing to the wound and stabilize the impaled object using sterile pads, kerlix roll, or field dressing to prevent motion.



06
APPLY additional dressings, if needed, by building up the area around the impaled object to further protect and stabilize the impaled object.



07
SECURE all dressings using tape, bandages, and/or cravats to hold bulky dressings in place.



08
If the wound is on an **EXTREMITY**, immobilize the extremity using a splint.

NOTE: Reassess pulse, motor, sensory upon splinting.



09
REASSESS dressing for hemorrhage control. REASSESS casualty for shock.



11
DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

CHEST SEAL



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



01 EXPOSE and uncover any anterior, posterior or axillary chest wounds.

NOTE: If multiple wounds are found, treat them in the order in which you found them.



02 CHECK for signs of an open and/or sucking chest wound.

NOTE: If you are not sure if the wound has penetrated the chest wall completely, treat the wound as though it were an open chest wound.



03 PLACE hand or back of hand over open chest wound to create a temporary seal.

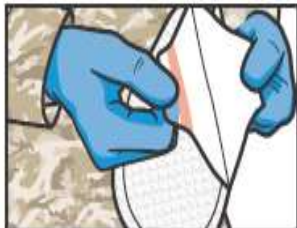


04 Fully OPEN the outer wrapper of the commercial vented chest seal or other airtight material from the casualty's JFAK.

NOTE: If a vented chest seal is not available, use a non-vented chest seal.



05 REMOVE gauze from vented chest seal package (or other gauze) to wipe away any dirt, blood, or other fluid.



06 PEEL OFF the protective liner, exposing the adhesive portion of the vented chest seal.



07 PLACE adhesive side directly over hole as casualty exhales, pressing firmly to vented chest seal.

NOTE: Ensure edge of vented chest seal extends 2" beyond edges of the wound.



08 ENSURE the adhesive surface of the vented chest seal is adhering to the skin.

NOTE: Tape may be used to secure the edges of the vented chest seal if needed.



09 ASSESS the effectiveness of the vented chest seal when the casualty breathes.

STEP 9 NOTE: When the casualty inhales, the plastic should be sucked against the wound, preventing air entry.

STEP 9 NOTE: When the casualty exhales, trapped air should be able to escape from the wound and out the commercial chest seal valve.

Continued on next page...

CHEST SEAL



10 **CHECK/FEEL** for additional open wounds (anterior, posterior, and axillary). Treat any additional wounds with vented chest seals if needed.



11 **PLACE** conscious casualty into a sitting position or an unconscious casualty in the recovery position (with their injured side down).



12 **MONITOR** for signs of a tension pneumothorax.

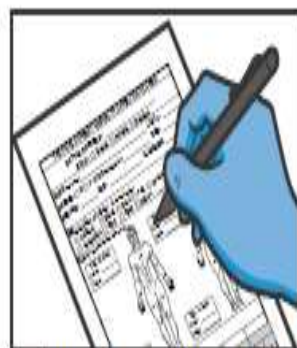


13 If signs of a tension pneumothorax develop, **LIFT** one edge of the vented chest seal to allow decompression ("burping" the seal)

NOTE: Alternatively, remove the chest seal for a few seconds to decompress and then reapply or replace it with a new commercial vented chest seal.



14 If signs of a tension pneumothorax persist despite burping the seal, **PERFORM** a needle decompression of the chest (see Needle Decompression of the Chest Instruction).



15 **DOCUMENT** all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

NEEDLE DECOMPRESSION OF THE CHEST (NDC)



CONSIDER body substance isolation.

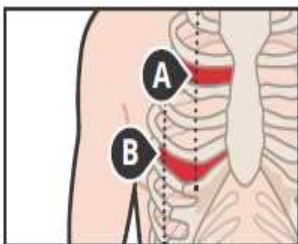
NOTE: If a Combat Lifesaver is available, direct them to assist.

- 01** ASSESS the casualty for signs of suspected tension pneumothorax.

NOTE: Signs of a tension pneumothorax include significant torso trauma or primary blast injury followed by severe/progressive respiratory distress (respiratory rate of less than 8 or greater than 20 breaths per minute, or an oxygen saturation <90%).



- 02** If a vented chest seal was previously applied, BURP it, or REPLACE the chest seal, if improperly applied and reassess the casualty.



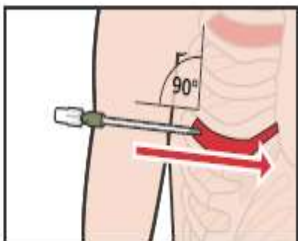
- 03** IDENTIFY site placement for needle insertion on the side of the injury (whichever one is more accessible):
- (a) Second intercostal space (ICS) at the midclavicular line on the side of the injury
 - NOTE:** Do not insert the needle medial to the nipple line.
 - (b) Fifth ICS in the anterior axillary line on the side of the injury



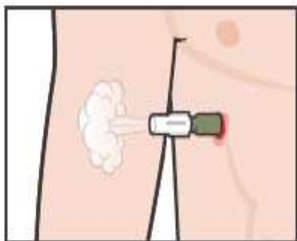
- 04** SECURE a 14-gauge or a 10-gauge, 3.25 in needle/catheter unit.
- NOTE:** Remove Luer lock cap from needle/catheter (if applicable).



- 05** If available, use an antiseptic solution or a pad to CLEAN the site.

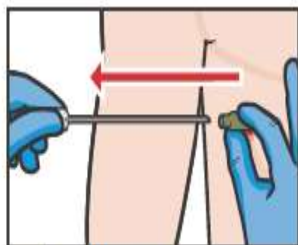


- 06** INSERT the needle/catheter just over the top of the lower rib at the insertion site, at a 90-degree angle (perpendicular) to the chest wall, advancing it to the hub.



- 07a** LEAVE the needle/catheter unit in place for 5–10 seconds to allow decompression to occur.

NEEDLE DECOMPRESSION OF THE CHEST (NDC)



07b REMOVE the needle, leaving the catheter in place.



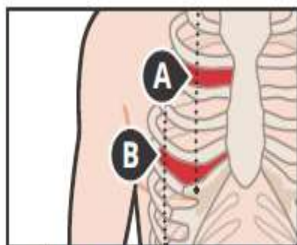
08 ASSESS for successful needle decompression:

- (a) Respiratory distress improves.
- (b) There is an obvious hissing sound as air escapes from the chest when NDC is performed.

NOTE: This may be difficult to appreciate in high-noise environments.

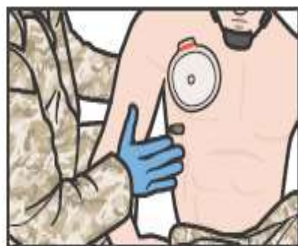
- (c) Hemoglobin oxygen saturation increases to 90% or greater (respiratory distress should improve).

NOTE: This may take several minutes and may not happen at altitude.



09 If the first NDC fails to improve the casualty's signs/symptoms, then **PERFORM** a second NDC on the same side of the chest at whichever of the two recommended sites was not previously used.

NOTE: Use a new needle/catheter unit for the second decompression attempt.



10 PLACE the casualty in the sitting position or recovery position (with their injured side down).

11 Continue reassessing the casualty for the reoccurrence of progressive respiratory distress.

12 If the initial NDC was successful, but symptoms later recur, then **PERFORM** another NDC at the same site that was used previously. Use a new needle/catheter unit for the repeat NDC.

13 If the second NDC is also not successful, then continue onto the Circulation section of the MARCH (Massive bleeding, Airway, Respiration, Circulation, Hypothermia/Head) sequence.



14 DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

PENETRATING EYE INJURY

01



PLACE the casualty in a comfortable position, one that allows you access to their eye (head).



REMOVE their headgear, if necessary.

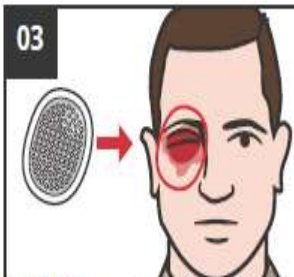
02



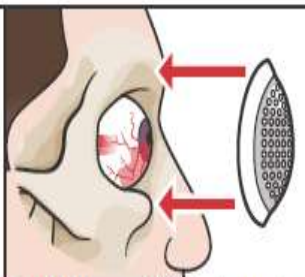
EXAMINE the eyes for any deformities, contusions, abrasions, penetrating objects, bruising (black eye(s)), lacerations, or swelling.

NOTE: Perform a rapid field test of visual acuity.

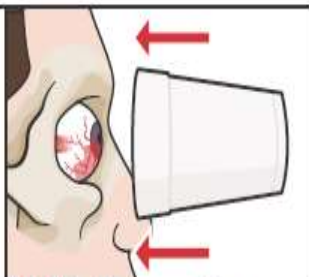
03



COVER the casualty's injured eye with a rigid eye shield (not a pressure patch).



NOTE: The eye shield is designed to rest on the bony prominence of the face arching over the eye structures.



NOTE: In the absence of an eye shield, other objects such as SAM splints, Styrofoam, or plastic cups can effectively perform the same function.

NOTE: Do not cover other eye (unless also injured).

NOTE: For protruding/impaired object in eye, cut a hole in the eye shield for the object to fit through and secure in place. If you cannot cut the eye shield, place a bulky dressing around the penetrating object.

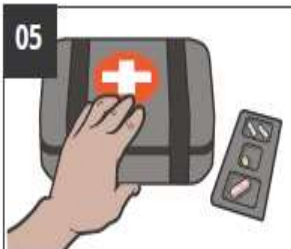
CAUTION: Ensure that the rigid eye shield or improvised object is not in contact with the contents of the eye socket or exerting any pressure on the eye. If the eye shield exerts pressure, use an improvised eye shield.

04



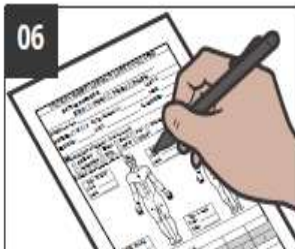
SECURE the rigid eye shield with tape at a 45-degree angle across the forehead and cheek.

05



If the casualty is conscious, **ADMINISTER** the Combat Wound Medication Pack (CWMP).

06



DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

RIGID EYE SHIELD



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



- 01** PLACE the casualty in a comfortable position, one that allows you access to their eyes (head).

NOTE: Remove their headgear, if necessary.



- 02** EXAMINE the eyes for any deformities, contusions, abrasions, penetrating objects, bruising (black eye(s)), lacerations, or swelling.

NOTE: Even if a penetrating wound is not obvious, treat any swelling or abrasions as this type of eye injury.

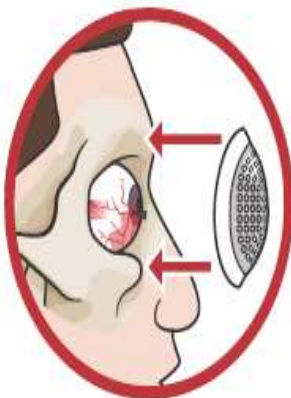


- 03** PERFORM a rapid field test of visual acuity (see Eye Trauma Visual Acuity Test Instruction).



- 04** COVER the casualty's injured eye with a rigid eye shield (not a pressure patch).

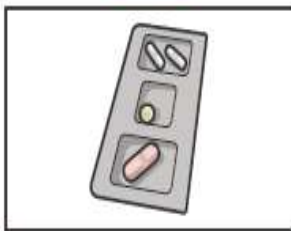
NOTE: Do not cover the unaffected eye (unless it is also injured).



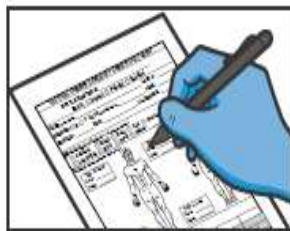
STEP 4 CAUTION: Ensure the rigid eye shield is not in contact with the contents of the eye socket, any impaled objects, or exerting pressure on the eye. If the eye shield exerts pressure, use an improvised eye shield (Styrofoam cup, etc.).



- 05** SECURE the rigid eye shield with tape at a 45-degree angle across the forehead and cheek.



- 06** ENSURE that the antibiotic tablet in the Combat Wound Medication Pack (CWMP) is taken. If unconscious and unable to take the oral antibiotic in the CWMP, then administer intravenous or intramuscular antibiotics as outlined (see Antibiotic Administration Instruction).



- 07** DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

RAPID VISUAL ACUITY TESTING



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.

- 01** Have the casualty cover the **UNAFFECTED** eye.

At an **ARM'S LENGTH**, assess the casualty's ability to:



- 02a** **READ** something with text on it (that you hold up).

NOTE: If the casualty is unable, follow the next step.



- 02b** **COUNT** fingers.

NOTE: If the casualty is unable, follow the next step.

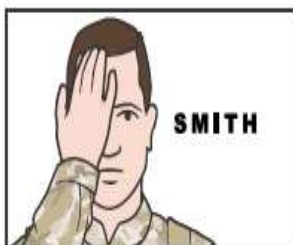


- 02c** **IDENTIFY** hand motion.

NOTE: If the casualty is unable, follow the next step.



- 02d** **IDENTIFY** light versus dark by covering and uncovering the eye.



- 03** **REPEAT** the procedure for the other eye.

NOTE: Do not force open a swollen eye to conduct a field visual acuity test.



- 04** **DETERMINE** acuity assessment findings based on what the casualty can see (e.g., can read text or count fingers at 2 feet).



- 05** **DOCUMENT** all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

NOTE: Include visual acuity for both eyes.

WOUND PACKING AND PRESSURE BANDAGE



01
EXPOSE the wound, if not previously exposed.



02
LOCATE the source of the most active bleeding and apply direct pressure.



03
REMOVE the dressing from its sterile package.



04
PACK it tightly into the wound directly over the site of the most active bleeding. Ensure the gauze extends 1-2 inches above the skin.

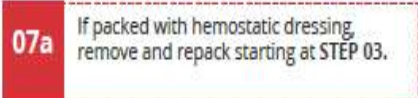


05
After packing HOLD pressure for minimum of 3 min.

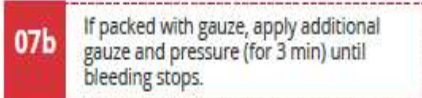


06
REASSESS to ensure bleeding has been controlled while maintaining pressure.

IF BLEEDING HAS NOT BEEN CONTROLLED:



07a
If packed with hemostatic dressing, remove and repack starting at STEP 03.



07b
If packed with gauze, apply additional gauze and pressure (for 3 min) until bleeding stops.



08
REMOVE the pressure bandage from the pouch and packaging.



09
PLACE the bandage pad over the wound, or dressing applied, by applying pressure.



10
WRAP tightly around the extremity ensuring that the edges of the pad are covered.



11
SECURE Velcro or closure bar onto the last bandage wrap.



12
CHECK for circulation by feeling for a distal pulse.



13
DOCUMENT all findings and treatments on the DD1380 TCCC Casualty Card.

SPLINT APPLICATION

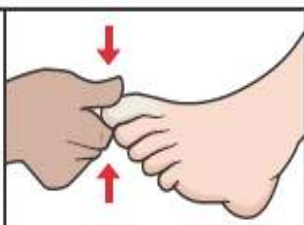


01 IDENTIFY the location of the fracture.

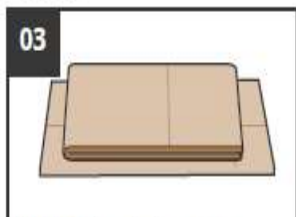
NOTE: Have the casualty or someone else manually stabilize the area.



02 Before applying the splint, **CHECK** the distal pulse (pulse below the fracture)...



and capillary refill (color returning to the nail bed after pressing on it) on the injured extremity.

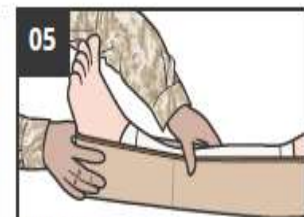


03 PREPARE the splint materials for application.

NOTE: Measure and shape the splint on the opposing uninjured extremity.



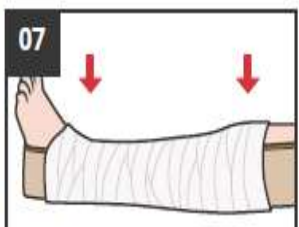
04 PREPARE securing materials (cravats, elastic wraps/bandages, etc.)



05 APPLY the splint to the injured extremity with the limb, in the position of function (a normal resting position), if possible.



06 SECURE the splint in place with appropriate materials.



07 ENSURE the joints above and below the fracture are immobilized in the splint whenever possible.



08 RECHECK the distal pulse after applying the splint. If the pulse is not palpable, loosen the splint, reposition, and reapply the splint.



09 If the casualty has pain, severe combat wounds, and is conscious and can swallow, **ADMINISTER** all pills (pain medication and antibiotics) from the CWMP with water.



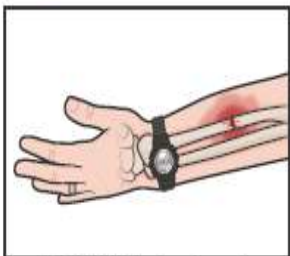
10 DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

MALLEABLE SPLINT INSTRUCTION



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver (CLS) is available, direct them to assist.



- 01 IDENTIFY** the location of the fracture and place the extremity in a neutral position or position of function.

STEP 1 NOTE: Direct the CLS or other first responder to manually stabilize the fracture site (without gross movement), when appropriate.



- 02 ASSESS** pulse, motor, and sensory (PMS) function distal to fracture.



- 03 REMOVE** jewelry, watch, clothing, and/or boots as the situation dictates.



- 04 ENSURE** that any open injuries are bandaged and bleeding has been controlled.



- 05 SELECT** the proper splinting material (e.g., SAM® Splint or other malleable aluminum foam splint, padding materials and material to secure the splint to the extremity).



- 06** Using the uninjured extremity on the opposite side of the casualty, **MEASURE AND FOLD** a malleable splint so that it encompasses the joint above and the joint below the fracture site.



- 07 APPLY** the formed malleable splint(s) to the injured extremity with the limb in a position of function (a normal resting position), avoiding gross movement if possible.



- 08 LIGHTLY PAD** all gaps within the splint, filling voids and protecting bony prominences, to make it more comfortable.

STEP 6 NOTE: Malleable splints are made rigid by introducing curves, particularly along the long axis of the splint, when molding the desired shape. Techniques (gutter splints, sugar tongs, etc.) vary based on location of fracture.

STEP 6 NOTE: It may be necessary to use two malleable splints, interlocked for stability, in some situations.

Continued on next page...

MALLEABLE SPLINT INSTRUCTION

Continued...



09 **TIE** cravats or cloth strips (and ensure that knots are tied over splinting material, not on the arm) or wrap elastic bandages around the splint to secure it in place.



10 **TUCK** in the ends of the cravats so that they will not get caught on obstacles during movement.



11 **ENSURE** the joints above and below the fracture are immobilized in the splint whenever possible.

STEP 9 NOTE: When using cravats, one must be placed proximal and the other distal to the fracture (if possible), understanding that in the case of a very proximal or distal fracture, this might not be possible.



12 **SECURE** the entire injured extremity (when appropriate). For example, a sling and swathe may be indicated to keep an arm fracture stabilized during transport.

NOTE: During movement, litter straps may keep the extremity from moving, but ensure the strap does not apply pressure directly on the fracture site.

13 **REASSESS** PMS (if PMS is no longer palpable, loosen the splint, reposition, and reapply the splint).

14 **ADMINISTER** pain medications as needed and antibiotics for any open fracture(s).



15 **DOCUMENT** all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

PULSE ASSESSMENT

CAROTID PULSE



RADIAL PULSE



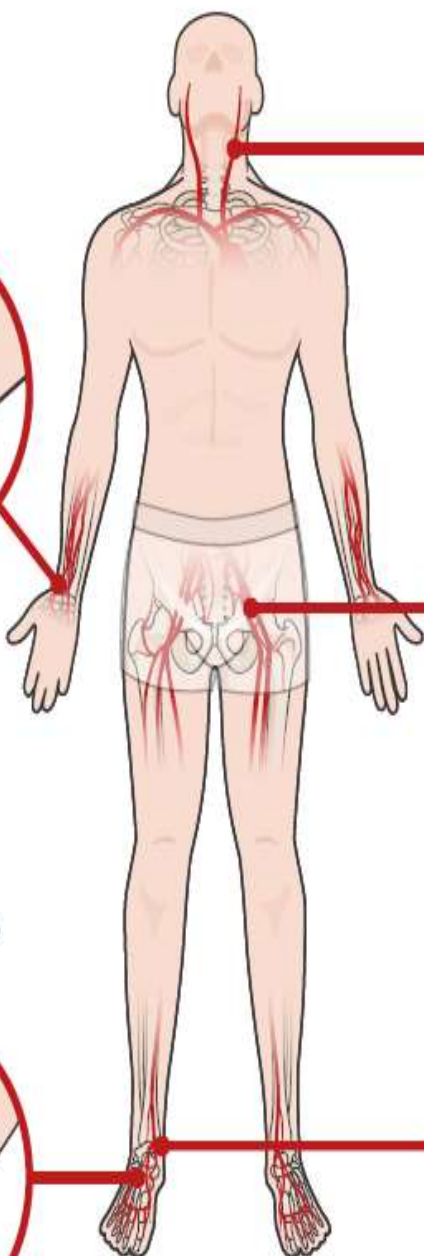
FEMORAL PULSE



DORSALIS PEDIS
(PEDAL) PULSE



POSTERIOR
TIBIAL PULSE



NASOPHARYNGEAL AIRWAY (NPA)



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



- 01** PLACE the casualty supine (on their back) with their head in a neutral position.



- 02** INSPECT nose and nasal passages for obstructions preventing insertion of NPA.



- 03** OPEN the NPA package provided in the casualty's JFAK.

NOTE: The standard NPA (size 32 Fr) that comes in most first aid kits fits an average-size Service Member.



- 04** LUBRICATE end of NPA device with the sterile water-based lubricating jelly found in the JFAK or with water.

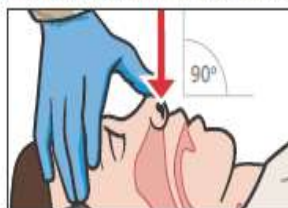


- 05** EXPOSE opening of casualty's *right* nostril by pushing the tip of the nose upward gently.



- 06** POSITION tube so that the beveled (open) end faces toward the septum.

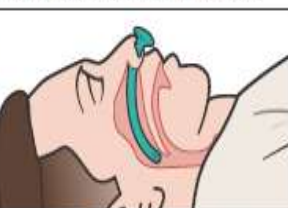
STEP 4 NOTE: Do not use blood or non-water-based substances; however, the casualty's (not your) saliva can be used.



- 07** INSERT NPA device into the right nostril (at a 90-degree angle to the casualty's face)...



...with the beveled tip pointed toward the middle of the nose. Using a fluid movement, ADVANCE the NPA...



...until the flange is flush with the nostril, pushing toward the ground, and not toward the top of the head.

CAUTION: Never force the NPA into the casualty's nostril. If resistance is met, attempt a slight twisting motion and try to gently reinsert. If successful, but the casualty begins to gag or choke, pull the NPA out slightly and leave it in place. If unsuccessful, pull out the NPA completely and attempt to insert it into the *left* nostril. If inserting in the left nostril, you will need to rotate the NPA after it is approximately 2" into the casualty's nose, so the curve of the NPA is oriented downward.



- 08** REASSESS breathing and respiration by using the LOOK, LISTEN, and FEEL technique.



- 09** POSITION casualty in either a sitting or recovery position. PLACE an unconscious casualty in the recovery position to prevent aspiration of blood, mucus, or vomit.



- 10** DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

Nasopharyngeal Airway (NPA) - Photos



TOURNIQUET CONVERSION



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



- 01** EXPOSE the wound, if not previously exposed.

NOTE: Remove clothing and equipment as required.

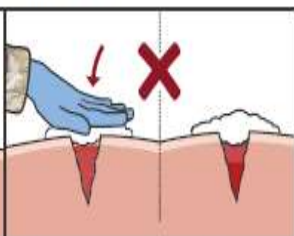
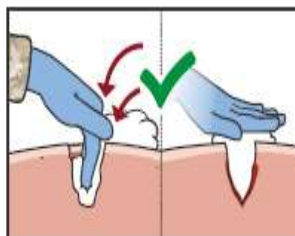


- 02** REMOVE the hemostatic dressing or gauze from its sterile package.

NOTE: If hemostatic dressing or gauze is not available, use clean, dry cloth material.



- 03a** PACK the dressing tightly into the wound.



- 03a** **STEP 3 NOTE:** Fill and pack the whole wound cavity tightly while keeping firm pressure on the wound. More than one hemostatic dressing or gauze may be required.

STEP 4 NOTE: If the hemostatic dressing or gauze does not extend 1–2" above the skin, place additional hemostatic dressing or gauze.

STEP 4 NOTE: If a penetrating object is lodged in the casualty's body, bandage it in place. Do not remove the object.



- 04** ENSURE the hemostatic dressing or gauze extends 1–2" above the skin.



- 05** AFTER packing, continue to apply firm, manual pressure for a minimum of 3 minutes.



- 06** REMOVE the pressure bandage from its package.



- 07** PLACE the pad of the pressure bandage directly over the wound or previously applied hemostatic dressing while continuing to apply direct pressure.

Continued on next page...

TOURNIQUET CONVERSION

Continued...



08 **WRAP** the pressure/elastic bandage tightly around the extremity, focusing pressure over the wound and ensuring that the edges of the pad are covered.

STEP 8 NOTE: If the bandage has a pressure bar, insert the elastic wrap completely into the pressure bar, pull the bandage tight, and reverse it back over the top of the pressure bar, forcing it down onto the pad.



09 **SECURE** the hooking ends of the hook and loop straps or closure bar onto the last wrap of the bandage.



10 **SLOWLY** release the tourniquet (over one minute); observe the bandage for bleeding.

STEP 10 NOTE: Convert tourniquets in less than 2 hours, if possible, but do not remove a tourniquet that has been in place more than 6 hours.

STEP 10 NOTE: If bleeding reoccurs, retighten the original tourniquet, ensuring bleeding is controlled and the distal pulse is absent.



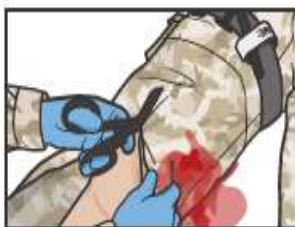
11 **DOCUMENT** all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

TOURNIQUET REPLACEMENT



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



- 01** EXPOSE the injury and assess the bleeding source.



- 02** ASSESS previously applied tourniquet(s) for effectiveness at controlling bleeding and proximity to the bleeding site.



- 03** Check for distal pulse.
NOTE: If distal pulse is present, attempt additional tightening. If distal pulse is still present, proceed immediately to STEP 4.



- 04** APPLY a CoTCCC-recommended tourniquet directly on skin 2-3" above the bleeding site if possible (see Tourniquet Application Instructions).



- 05** SLOWLY release the original tourniquet(s) over one minute.



- 06** WATCH the area where bleeding originally took place, ensuring no bleeding reoccurs.



- 07** ASSESS to ensure distal pulse is absent, and bleeding is still controlled.



- 08** SLIDE originally placed tourniquet(s) down, but leave in place proximal to the newly placed tourniquet.

STEP 6 NOTE: If bleeding reoccurs, immediately retighten the initial tourniquet(s), ensuring bleeding is controlled, and further tighten the newly applied tourniquet. Repeat Steps 5 & 6 until the new tourniquet controls bleeding.

STEP 8 NOTE: replaced tourniquets should not be fully tightened, but excess slack should be removed.



- 09** ANNOTATE the time of the new tourniquet placement on the tourniquet.



- 10** DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

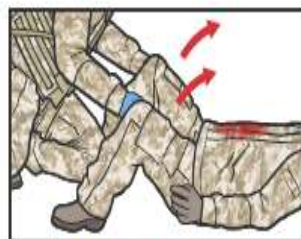
OPEN ABDOMINAL WOUND

CAUTION: The size of the external wound is not a safe guideline for judging its severity



CONSIDER body substance isolation.

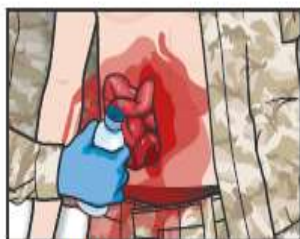
NOTE: If a Combat Lifesaver is available, direct them to assist.



- 01** PLACE the casualty in the supine position, with knees flexed.



- 02** EXPOSE the wound, inspecting for deformities, contusions, abrasions, penetrations, burns, lacerations, and swelling, and most importantly, tenderness, rigidity, distention, and pulsating masses.



- 03a** RINSE the wound with clean (and warm if possible) fluid to reduce gross contamination.



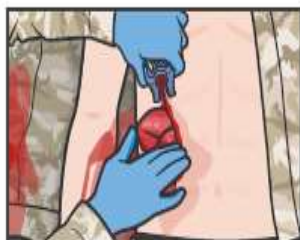
- 03b** **STEP 3 NOTE:** Apply combat gauze or CoTCCC-recommended hemostatic dressing or hemostatic agent to any uncontrolled bleeding.



- 04** If no evidence of bowel leakage and hemorrhage is visibly controlled, a single brief attempt (<60 seconds) may be made to replace/reduce the eviscerated abdominal contents.

CAUTION: Do NOT attempt if there is evidence of ruptured bowel (gastric/intestinal fluid or stool leakage) or active bleeding.

CAUTION: DO NOT force contents back into abdomen or actively bleeding viscera or remove foreign objects.



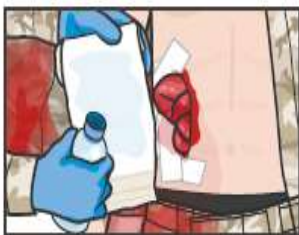
- 05** If reduction attempt is successful, RE-APPROXIMATE the skin using available material, preferably an adhesive dressing (chest seal, for example) or with staples, sutures or a wound closure device.

- 06** STABILIZE any protruding objects (see Impaled Object Skill Card).

Continued on next page...

OPEN ABDOMINAL WOUND

Continued...



- 07** COVER exposed bowel with moist, sterile abdominal dressings, if available.

STEP 7 NOTE: Protruding abdominal organs should be kept moist to prevent the tissue from drying out.

- (a) Ensure that the dressing is large enough to cover the entire mass of protruding organs or area of the wound.
- (b) Using the sterile side of the dressing, or other clean, damp material, gather or keep any protruding organs near the wound and cover the wound.

STEP 7 NOTE: Do not touch exposed organs with bare hands.

- (c) If using a dressing with tails, tie loosely and do not tie directly over the wound.



- 08** COVER the dressed, eviscerated organs with water impermeable non-adhesive material (preferably transparent to allow re-assessment for ongoing bleeding). Examples include the sterile side of a plastic wrapper, IV bag, clear food wrap, etc.

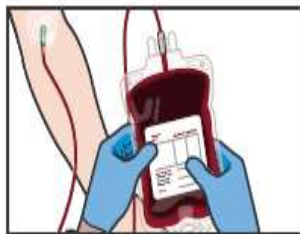
CAUTION: DO NOT apply pressure on the wound or further expose internal organs.



- 09** SECURE the impermeable dressing to the patient using adhesive bandage (examples: medical tape, chest seal).

NOTE: If an adhesive bandage isn't available, loosely cover the dressing with cravats and tie them on the side of the casualty opposite that of the dressing ties (if present).

NOTE: Use multiple dressings and cravats, if needed, to cover a large wound, ensuring tails of additional dressings are not tied over each other.



- 10** ASSESS AND TREAT the casualty for shock and continue to reassess periodically.

NOTE: The most important concern in the initial management of abdominal injuries is shock.

CAUTION: Shock may be present initially or may develop later.



- 11** PREVENT hypothermia as exposed abdominal contents will result in more rapid heat loss.



- 12** DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

AXILLARY JUNCTIONAL HEMORRHAGE CONTROL



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.

EXPOSE the injury and assess the bleeding source.

NOTE: Clothing may need to be cut away to properly expose the injury.



- 01** LIFT the arm to expose the wound and assess the bleeding source.



- 02** APPLY direct pressure to the most active bleed.



- 03** Using the casualty's JFAK, remove the hemostatic dressing from its sterile package.

- 04** EXTEND the casualty's arm at a 90-degree angle by placing it on your shoulder (to maintain elevation of the arm), while proceeding through steps 5-13.

NOTE: The best position to treat the casualty is the seated position. If the casualty cannot be treated in the seated position, you will need to sit the casualty up as much as possible to apply the elastic bandage.

NOTE: If a hemostatic dressing is not available, use gauze or clean, dry cloth material.



- 05** PACK the axillary wound tightly with hemostatic dressing or gauze until the wound cavity is filled while keeping firm pressure on the wound (finishing within 90 secs).

NOTE: More than one hemostatic dressing or gauze may be required to stop the blood flow.

CAUTION: If a penetrating object is lodged into the casualty's body, bandage it in place. **DO NOT** remove the object.



- 06** ENSURE Ensure the hemostatic dressing or gauze extends 1-2 inches above the skin.

NOTE: If the hemostatic dressing or gauze does not extend 1-2 inches above the skin, place additional hemostatic dressing or gauze.



- 07** HOLD pressure for a minimum of 3 min.

- 08** REASSESS to ensure bleeding has been controlled while maintaining pressure.

NOTE: Ensure blood is not seeping through or around the hemostatic dressing. If bleeding has stopped, leave the hemostatic dressing in place while still maintaining pressure.

IF BLEEDING HAS NOT BEEN CONTROLLED:

09a If packed with hemostatic dressing, remove prior packing material, and repack starting at STEP 3.

OR

09b If packed with gauze or other materials, apply additional gauze/materials and pressure (for another 3 minutes) until bleeding has stopped.

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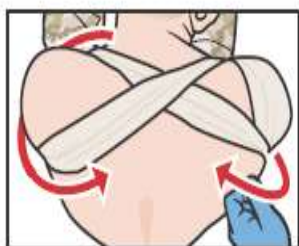
AXILLARY JUNCTIONAL HEMORRHAGE CONTROL

Continued...



10 While maintaining pressure on the hemostatic dressing or gauze, **WRAP** the pressure (or elastic) bandage around injured shoulder twice ensuring hemostatic dressing or gauze underneath is completely covered.

NOTE: If using an elastic bandage without a closure bar, leave a tail on the posterior side of the casualty.



11 **WRAP** the elastic bandage across, back, and under the opposite axilla, anchoring around the opposite shoulder in a "Figure 8" pattern.



12 Depending on the bandage used, **SECURE** with the closure bar or tie the tails of the elastic bandage together with a non-slip knot.



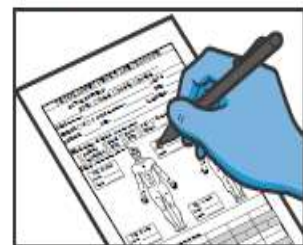
13 **SECURE** pressure (elastic) bandage tails and knot using 3-inch tape, wrapping the tape a minimum of 1½ times around the knot.



14 **SWATH** the upper arm on the injured side to the chest using a cravat.



15 **CONTINUE TO ASSESS** the wound for further bleeding.



16 **DOCUMENT** all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

INGUINAL HEMORRHAGE CONTROL

with improvised junctional pressure delivery device (PDD)



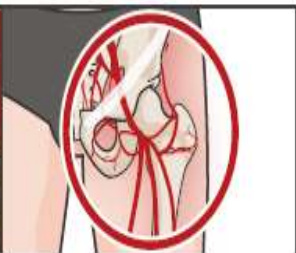
CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.

01

EXPOSE the injury and assess the bleeding source.

NOTE: Clothing may need to be cut away to properly expose the wound.



02

APPLY DIRECT PRESSURE to the source of most active bleeding; if not visible, **PLACE** a fist squarely in the inguinal gutter on the injured side.

NOTE: The inguinal gutter is the crevice between the top of the thigh and the lower abdomen where heavy blood flow structures are located. Location is halfway between the pubic bone and the anterior iliac spine.

03

Using the casualty's JFAK, **REMOVE** the hemostatic dressing from its sterile package.

NOTE: If hemostatic dressing is not available, use gauze or clean, dry cloth.



04

Remove fist, if used for initial bleeding control, and immediately **APPLY DIRECT PRESSURE** and **TIGHTLY PACK** the wound with hemostatic dressing until the wound cavity is filled (finishing the packing within 90 seconds).

NOTE: More than one dressing/gauze may be required to stop blood flow.

CAUTION: If a penetrating object is lodged in the casualty's body, bandage it in place. **DO NOT** remove the object.

05

ENSURE hemostatic dressing or gauze fills the entire wound cavity and extends 1-2" above the skin.

NOTE: If the hemostatic dressing or gauze does not extend 1-2 inches above the skin, place additional hemostatic dressing or gauze.



06

HOLD pressure for minimum of 3 minutes.

07

REASSESS to ensure bleeding has been controlled while maintaining pressure.

IF BLEEDING HAS NOT BEEN CONTROLLED:

08a If packed with hemostatic dressing, remove and repack starting at STEP 3.

OR

08b If packed with gauze, apply additional gauze and pressure (for 3 min) until bleeding stops.

STEP 7 NOTE: Ensure blood is not seeping through or around the hemostatic dressing. If bleeding has stopped, leave the hemostatic dressing in place while still maintaining pressure.

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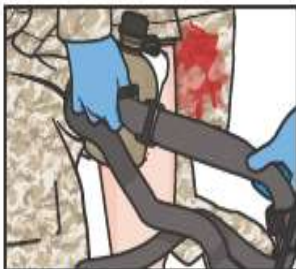
INGUINAL HEMORRHAGE CONTROL

with improvised junctional pressure delivery device (PDD)

Continued...



09 SELECT a cylindrical or spherical PDD and position into the inguinal gutter while continuously maintaining pressure to the hemostatic dressing. (PDD examples: shoe/boot, full water bottle, canteen.)



10 SELECT a tourniquet that can wrap around the casualty's waist/hip area or connect two tourniquets.



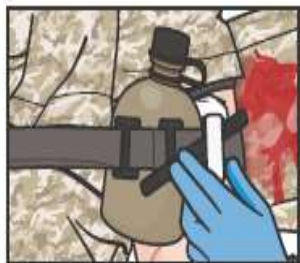
11 PLACE the windlass or ratchet tourniquet directly over the middle of the PDD; ensure that the routing buckle is located toward the medial aspect of the body.



12 REMOVE all slack from the self-adhering band or strap using a pushing motion across the casualty's body before tightening the tourniquet.



13 TIGHTEN the tourniquet until bleeding has stopped and the distal pulse has been checked and is absent.



14 Visually INSPECT placement of equipment, ensuring the PDD is in place and the windlass/ratchet is properly positioned over the device.



15 DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

STEP 13 NOTE: If bleeding is not controlled and a distal pulse below the tourniquet is present, remove any remaining slack in the strapping (if possible) and twist or ratchet the tourniquet device until bleeding is controlled and the distal pulse is absent.

NECK JUNCTIONAL HEMORRHAGE CONTROL



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.

01

EXPOSE the injury and assess the bleeding source.

NOTE: Clothing may need to be cut away to properly expose the injury.



02

APPLY DIRECT PRESSURE to bleeding source.

03

REMOVE hemostatic dressing from casualty's JFAK.

NOTE: If hemostatic dressing is not available, use gauze or clean, dry cloth material.



04

PACK wound tightly with hemostatic dressing until the wound cavity is filled. Continue to apply pressure. Finish packing within 90 sec.

NOTE: More than one dressing/gauze may be required to stop blood flow.

CAUTION: If a penetrating object is lodged in the casualty's body, bandage it in place. **DO NOT** remove the object.



05

ENSURE hemostatic dressing or gauze extends 1-2" above the skin.

NOTE: If the hemostatic dressing or gauze does not extend 1-2" above the skin, place additional hemostatic dressing or gauze.



06

After packing, continue to apply firm, manual pressure until the bleeding stops. **HOLD** pressure for a minimum of 3 min.



07

REASSESS to ensure bleeding has been controlled while maintaining pressure.

NOTE: Ensure blood is not seeping through or around the hemostatic dressing. If bleeding has stopped, leave the hemostatic dressing in place while still maintaining pressure.

IF BLEEDING HAS NOT BEEN CONTROLLED:

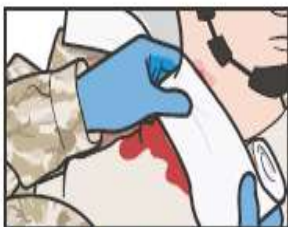
08a

If packed with hemostatic dressing, remove prior packing material and repack starting at STEP 3.

OR

08b

If packed with gauze, apply additional gauze/materials and pressure (for 3 min) until bleeding stops.



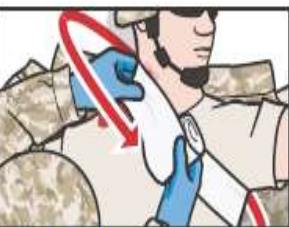
09

PLACE a 6" elastic bandage over the hemostatic dressing, leaving enough tail to tie it into a knot.



10

While maintaining pressure, **WRAP** bandage (no less than 1½ times) over the packing material covering it completely.



WRAP diagonally across the chest under the opposite arm (axilla) around the back to the neck and back over the wound.

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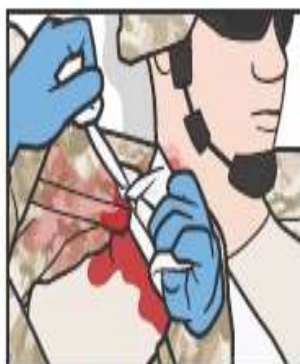
NECK JUNCTIONAL HEMORRHAGE CONTROL

Continued...



11 **WRAP** around neck and under the arm (on alternating sides of the tail, while maintaining tension/pressure), pulling elastic bandage tightly for pressure, covering the packing material.

NOTE: Do not use pressure bar on the neck.



12 **SECURE** the dressing by tying a non-slip knot with end of elastic bandage and its tail.



13 **SECURE** elastic bandage tails with 3" tape, wrapping a minimum of 1½ times around the knot.



14 **SWATHE** the upper arm (of the uninjured side) to the chest using a bandage.



15 **CONTINUE TO ASSESS** wound for further bleeding.



16 **DOCUMENT** all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

ONE-PERSON BAG VALVE MASK (BVM)



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



01 POSITION yourself at the top of the patient's head.



02 INSERT a nasopharyngeal airway.



03 ASSEMBLE the BVM (connect the mask to port on the bag).



04 PERFORM an "EC" technique to hold the mask in place over the patient's mouth by using this procedure:
NOTE: The EC hand position technique is performed using one hand.



FORMING the "C" by placing your thumb over the part of the mask covering the bridge of the nose and your index finger over the part covering the cleft of the chin.



SEALING mask firmly on the face by pushing down with thumb and index finger, while pulling up on the mandible. FORM the "E", opening the airway by performing head-tilt/chin-lift maneuver.



05 MAINTAIN a leakproof mask seal with one hand using firm pressure to hold the mask in position and seal over the patient's mouth.



06 SQUEEZE the bag with your other hand for 1-2 seconds while observing the chest rise to make certain lungs are inflating effectively.



07 CONTINUE SQUEEZING the bag once every 5-6 seconds (10-12 breaths/minute).

NOTE: Alternatively, the bag may be compressed against your leg or forearm to deliver a greater tidal volume to the patient or help with hand fatigue.



08 CONTINUE ventilation, observe for spontaneous respirations, and periodically check the pulse.



09 DOCUMENT all findings and treatments on the DD Form 1380 TCCC Casualty Card and attach it to the casualty.

BURN TREATMENT

NOTE: All TCCC interventions can be performed on or through burned skin in a burn casualty.



CONSIDER body substance isolation.

NOTE: If a Combat Lifesaver is available, direct them to assist.



01 **ELIMINATE** the source of the burn.



02 After removing the casualty from the source of the burn:

a Aggressively **MONITOR** **AIRWAY STATUS** (for facial burns, especially those that occur in closed spaces) and consider early surgical airway for respiratory distress, associated with inhalation injury.

b Cut clothing around the burned area.

c Gently lift clothing away from burned area.

CAUTION: Do not force clothing off that is stuck to burnt skin.

03 **ESTIMATE** total body surface area (TBSA) burned to the nearest 10%.

04 If the casualty's hand(s) or wrist(s) have been burned, **REMOVE** jewelry (rings, watches) and place them in the casualty's pockets.



05 **APPLY** sterile, dry dressings to burned skin areas.



06 **KEEP** the casualty warm and prevent hypothermia.



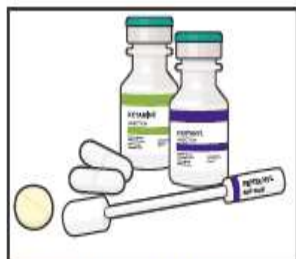
07 For burns greater than 20% total body surface area (TBSA), initiate **FLUID RESUSCITATION** according to the USAISR Rule of Ten.

STEP 6 NOTE: For extensive burns (>20%), place the casualty in the insulated hypothermia enclosure system to both cover the burned areas and prevent hypothermia.

Continued on next page...

BURN TREATMENT

Continued...



- 08** ANALGESIA MAY BE ADMINISTERED to treat burn pain.



- 09** ADMINISTER ANTIBIOTICS if penetrating wounds are found, to prevent infection.



- 10** Burn patients are particularly susceptible to hypothermia. Extra emphasis should be placed on PREVENTION OF HEAT LOSS.

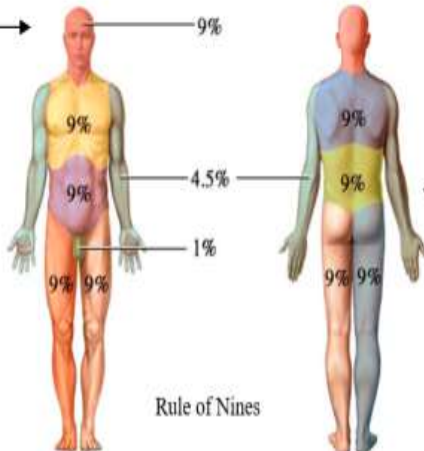


- 11** MONITOR the casualty closely for life-threatening conditions, check for other injuries, and treat for shock (if applicable).



- 12** DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach it to the casualty.

Front of head is 4.5% and back of head is 4.5% for a total of 9%



Rule of Nines

Front of arm is 4.5% and back of arm is 4.5% for a total of 9%

HYPOTHERMIA PREVENTION AND TREATMENT

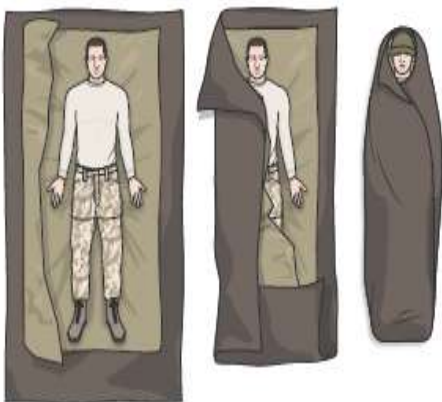
NOTE: Aggressive steps should be taken early to prevent further loss of body heat and, when possible, actively warm (by adding external heat) trauma and burn casualties.

-  **CONSIDER** body substance isolation.
NOTE: If a Combat Lifesaver is available, direct them to assist.
NOTE: Ensure hemostasis, assess, and treat for hemorrhagic shock.

- 01** MINIMIZE the casualty's exposure to the elements.
- 02** PLACE insulation material between casualty and cold surface as soon as possible.
- 03** KEEP DRY CLOTHING and protective gear on or with the casualty.
- 04** REMOVE WET CLOTHES and replace with dry clothes/materials, if possible.



- 05** If using a hypothermia kit, REMOVE the vapor barrier shell, open completely, and PLACE the casualty centered on the shell.
- 06** If commercial vapor barrier shell is not available, PLACE the casualty centered on an impermeable vapor barrier (space blanket, survival blanket, plastic tarp, waterproof sleeping bag shell, body bag, etc.).
- 07** If an active warming device is available, open the active warming device package, REMOVE the device, and EXPOSE to air (per manufacturer's guidance).
- 08** APPLY the active warming device on the casualty's anterior torso and under the arms in the axillae.
CAUTION: Do not place the active warming device directly on the skin to prevent burns.
- 09** If an active warming device is not available, WRAP passive warming materials (blanket, etc.) under and around the casualty, including the head.
CAUTION: Passive hypothermia prevention does not reverse the hypothermic process.



- 10** WRAP the entire vapor barrier shell (or other improvised impermeable vapor barrier materials) completely around the casualty, including the head and secure using tape if necessary.
- 11** PROTECT the casualty from further exposure to wind and precipitation while awaiting evacuation.
- 12** MONITOR the casualty closely for life-threatening conditions.
- 13** DOCUMENT all findings and treatments on a DD Form 1380 TCCC Casualty Card and attach to the casualty.

STEP 10 NOTE: Do not cover up the casualty's face.

STEP 10 NOTE: As soon as possible, upgrade any improvised vapor barrier to a well-insulated enclosure system as additional materials become available.

STEP 10 NOTE: As a planning factor, pre-stage an insulated hypothermia enclosure system with external active heating for transition from non-insulated hypothermia enclosure systems.

SUGGESTED SUPPLIES FOR A HYPOTHERMIA WRAP:

- | | |
|---|--|
| 1 - Tarp or plastic sheet for vapour barrier outside sleeping bag | 1 - Plastic or foil sheet (2 x 3 m) for vapour barrier placed inside sleeping bag |
| 1 - Insulated ground pad | 1 - Source of heat (e.g., chemical heating pads/blankets or warm water in a bottle or hydration bladder) |
| 1 - Hooded sleeping bag (or equivalent) | |
-

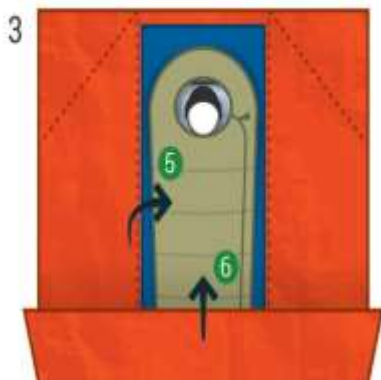
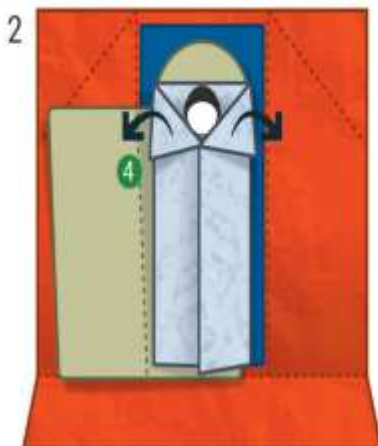
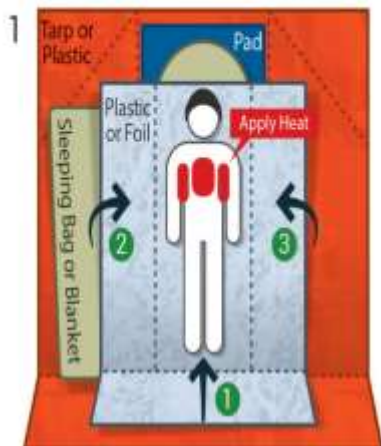
INSTRUCTIONS FOR HYPOTHERMIA WRAP

1. Dry or damp clothing: *Leave clothing on*

*IF shelter/transport is less than 30 minutes away,
THEN wrap immediately*

2. Very wet clothing:

*IF shelter/transport is more than 30 minutes away,
THEN protect person from environment,
remove wet clothing, and wrap*



5

Behavioural Changes to help Identify Hypothermia

Behaviour is a key indicator of hypothermia in a pre-hospital setting due to the challenges of determining an exact body temperature. The well described behavioural changes below are colloquially referred to as the 'umbles':

1

STUMBLES



- Loss of control over movements
- Slowed motion
- Stiffness in extremes

2

MUMBLES



- Slurred or slow or incoherent speech
- Sleepiness
- Confusion

3

FUMBLES



- Slow reaction time
- Dropping objects
- Poor co-ordination

4

GRUMBLES



- Change in behaviour
- Expressing a negative attitude
- Paradoxical undressing



5

CRUMBLES

- Life threatening
- Inability to walk
- Consciousness decreasing
- Decreased heart/respiratory rate
- Cardiac arrest

Glasgow Coma Scale

EYE OPENING		VERBAL RESPONSE		MOTOR RESPONSE	
					
Spontaneous	> 4	Orientated	> 5	Obey commands	> 6
To sound	> 3	Confused	> 4	Localising	> 5
To pressure	> 2	Words	> 3	Normal flexion	> 4
None	> 1	Sounds	> 2	Abnormal flexion	> 3
		None	> 1	Extension	> 2
				None	> 1
GLASGOW COMA SCALE SCORE					
Mild 13-15		Moderate 9-12		Severe 3-8	

Glasgow Coma Scale		
Response	Scale	Score
Eye Opening Response	Eyes open spontaneously	4 Points
	Eyes open to verbal command, speech, or shout	3 Points
	Eyes open to pain (not applied to face)	2 Points
	No eye opening	1 Point
Verbal Response	Oriented	5 Points
	Confused conversation, but able to answer questions	4 Points
	Inappropriate responses, words discernible	3 Points
	Incomprehensible sounds or speech	2 Points
	No verbal response	1 Point
Motor Response	Obeys commands for movement	6 Points
	Purposeful movement to painful stimulus	5 Points
	Withdraws from pain	4 Points
	Abnormal (spastic) flexion, decorticate posture	3 Points
	Extensor (rigid) response, decerebrate posture	2 Points
	No motor response	1 Point
Minor Brain Injury = 13-15 points; Moderate Brain Injury = 9-12 points; Severe Brain Injury = 3-8 points		

GLASGOW COMA SCALE : Do it this way

Institute of Neurological Sciences NHS Greater Glasgow and Clyde



CHECK

For factors Interfering with communication, ability to respond and other injuries



OBSERVE

Eye opening , content of speech and movements of right and left sides



STIMULATE

Sound: spoken or shouted request
Physical: Pressure on finger tip, trapezius or supraorbital notch



RATE

Assign according to highest response observed

Eye opening

Criterion	Observed	Rating	Score
Open before stimulus	✓	Spontaneous	4
After spoken or shouted request	✓	To sound	3
After finger tip stimulus	✓	To pressure	2
No opening at any time, no interfering factor	✓	None	1
Closed by local factor	✓	Non testable	NT

Verbal response

Criterion	Observed	Rating	Score
Correctly gives name, place and date	✓	Orientated	5
Not orientated but communication coherently	✓	Confused	4
Intelligible single words	✓	Words	3
Only moans / groans	✓	Sounds	2
No audible response, no interfering factor	✓	None	1
Factor interfering with communication	✓	Non testable	NT

Best motor response

Criterion	Observed	Rating	Score
Obey 2-part request	✓	Obeys commands	6
Brings hand above clavicle to stimulus on head/neck	✓	Localising	5
Bends arm at elbow rapidly but features not predominantly abnormal	✓	Normal flexion	4
Bends arm at elbow, features clearly predominantly abnormal	✓	Abnormal flexion	3
Extends arm at elbow	✓	Extension	2
No movement in arms / legs, no interfering factor	✓	None	1
Paralysed or other limiting factor	✓	Non testable	NT

Revised Trauma Score

Glasgow Coma Scale (GCS)	Systolic Blood Pressure (mmHg)	Respiratory Rate (breaths/min)	Coded Value
13-15	>89	10-29	4
9-12	76-89	>29	3
6-8	50-75	6-9	2
4-5	1-49	1-5	1
3	0	0	0

The Revised Trauma Score (RTS) is made up of a combination of results from three categories:

- * Glasgow Coma Scale

- * Systolic Blood Pressure

- * Respiratory rate

All of these results can be quickly assessed with minimal equipment: a flashlight, a watch and a sphygmomanometer since systolic pressure can be obtained through arterial palpation.

The score range is 0-12. In START triage, a patient with an RTS score of

12 is labeled **DELAYED** (walking wounded)

11 is **URGENT** (intervention is required but the patient can wait a short time)

10-3 is **IMMEDIATE** (immediate intervention is necessary)

<3 is **MORGUE**, which is given to seriously injured people. These people should not receive certain care because they are unlikely to survive. The reasoning is that diverting scarce resources away from people with a little chance of survival increases the chances of survival of others who are inherently more likely to survive.

Add the value of each characteristic. Highest possible total score is 12, and the lowest possible total score is 0.

National Guideline for the Field Triage of Injured Patients

RED CRITERIA High Risk for Serious Injury

Injury Patterns	Mental Status & Vital Signs
• Penetrating injuries to head, neck, torso, and proximal extremities • Skull deformity, suspected skull fracture • Suspected spinal injury with new motor or sensory loss • Chest wall instability, deformity, or suspected flail chest • Suspected pelvic fracture • Suspected fracture of two or more proximal long bones • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Active bleeding requiring a tourniquet or wound packing with continuous pressure	All Patients • Unable to follow commands (motor GCS < 6) • RR < 10 or > 29 breaths/min • Respiratory distress or need for respiratory support • Room-air pulse oximetry < 90% Age 0-9 years • SBP < 70mm Hg + (2 x age in years) Age 10-64 years • SBP < 90 mmHg or • HR > SBP Age ≥ 65 years • SBP < 110 mmHg or • HR > SBP

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA Moderate Risk for Serious Injury

Mechanism of Injury	EMS Judgment
• High-Risk Auto Crash - Partial or complete ejection - Significant intrusion (including roof) • >12 inches occupant site OR • >18 inches any site OR • Need for extrication for entrapped patient - Death in passenger compartment - Child (age 0-9 years) unrestrained or in unsecured child safety seat - Vehicle telemetry data consistent with severe injury • Rider separated from transport vehicle with significant impact (eg, motorcycle, ATV, horse, etc.) • Pedestrian/bicycle rider thrown, run over, or with significant impact • Fall from height > 10 feet (all ages)	Consider risk factors, including: • Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact • Anticoagulant use • Suspicion of child abuse • Special, high-resource healthcare needs • Pregnancy > 20 weeks • Burns in conjunction with trauma • Children should be triaged preferentially to pediatric capable centers If concerned, take to a trauma center

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

FOR PEOPLE AT REST	Adult (over 12 years)	Child (6 to 12 years)	Baby (1 to 5 years)	Newborn (less than 1 year)
Normal pulse rate (beats per minute)	60 – 100	80 – 100	100 – 120	120 - 160
Normal systolic blood pressure (mm Hg)	100 – 120 (but varies a lot)	90 – 110	80 – 90	70 – 90
Normal respiratory rate (chest movements, breaths per minute)	12 – 20	20 - 25	25 – 30	30 - 40

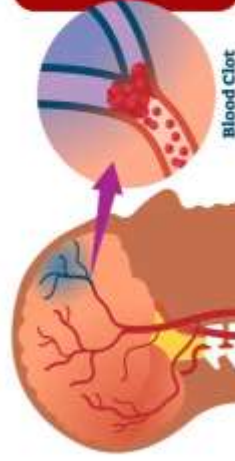
For each degree Celsius or Fahrenheit of fever, the heartbeat usually increases about 20 beats per minute. The respiratory rate increases as well.

To obtain the rate:

- count the number of beats (pulse felt by your fingers) in a 30-second period, and multiply by 2;
- count the number of breaths (inhalation + exhalation) in a 30-second period, and multiply by 2;
- try to avoid letting the casualty know that you are counting.

Body temperature of people at rest

Hypothermia	below 35.5 °C (95.9 °F)
Normal	35.5 – 37 °C (95.9 – 98.6°F)
Fever	37 – 39 °C (98.6 – 102.2 °F)
High fever	39 °C (102.2 °F) and over



Blood Clot

STROKE SYMPTOMS

LEARN THE WARNING SIGNS!

B



BALANCE

Loss of Balance,
Headache or Dizziness

E



EYES

Blurred Vision

F



FACE

One Side of the Face
Drooping

A



ARMS

Arm or Leg
Weakness

S



SPEECH

Speech Difficulty

T



TIME

Time to CALL for
Ambulance Immediately

Emergency Wound Care After a Natural Disaster



Take the following steps to protect yourself and your family:



Avoid contact with flood waters if you have an open wound.



Keep open wounds as clean as possible by washing thoroughly with soap and clean water.



Cover clean, open wounds with a waterproof bandage to reduce chance of infection.



Seek immediate medical care if a wound develops redness, swelling, or oozing or other signs of working infection such as fever, increasing pain, shortness of breath, fast heart rate, or confusion or disorientation, high heart rate.



Seek medical attention as soon as possible if:

- There is a foreign object (soil, wood, metal, or other objects) embedded in the wound;
- A wound is a result of an animal bite;
- A wound is a result of a puncture by a dirty object;
- The wound is infected (pain and soreness, swelling, redness, draining, or you develop a fever);
- You have signs of sepsis such as confusion or disorientation, shortness of breath, high heart rate, fever or shivering, extreme pain or discomfort or clammy or sweaty skin.

Take care of wounds:

- Wash your hands thoroughly with soap and clean water, if possible.
- Avoid touching the wound with your fingers while treating it (if possible, use disposable gloves).
- Remove obstructive jewelry and clothing from the injured body part.
- Apply direct pressure to any bleeding wound to control bleeding.
- Clean the wound after bleeding has stopped.
 - » Examine wounds for dirt and foreign objects.
 - » Gently flood the wound with bottled water or clean running water (if available, saline solution is preferred).
 - » Gently clean around the wound with soap and clean water.
 - » Pat dry and apply an adhesive bandage or dry clean cloth.
- Leave unclean wounds, bites and punctures open. Wounds that are not cleaned correctly can trap bacteria and result in infection.
- Provide pain relievers when possible.
- Review the wound every 24 hours.



If you have wounds, you should be evaluated for a tetanus immunization. If you receive a puncture wound or a wound contaminated with feces, soil, or saliva, have a health care professional determine whether a tetanus booster is necessary based on individual records.



Wound irrigation is an essential part of wound management and is the single greatest intervention in wound care to reduce the risk of infection.

Solutions Appropriate for Wound Care

Solution	Preparation	Notes
Povidone iodine	Comes pre-made in containers. Best diluted for dressings: 1 part povidone iodine to at least 3 or 4 parts saline or sterile water.	Toxic to healthy tissues; best used in diluted form for only a few days- then change to a milder solution. Safe on the face and around the eyes.
Saline	Comes pre-made, but easy to make yourself. To 1 liter of water add 1 tsp salt. Boil the solution for at least 60 seconds and allow to cool. Store in a closed, sterile container and refrigerate if possible. Good for several days.	Safe anywhere on the body.
Sterile water	Boil a liter of water for at least 60 seconds and allow to cool. Store in a closed, sterile container and refrigerate if possible. Good for several days.	Safe anywhere on the body.
Dakin's solution	Some pharmacies keep Dakin's solution in stock, but it is easy to make. To 1 liter of saline solution, add 5-10 cc of liquid bleach. Store in a closed, sterile container and refrigerate if possible. If your pharmacy carries Dakin's solution, it's best used diluted: 1 part Dakin's solution mixed with 3-4 parts saline.	Better antibacterial agent than saline- so a little harsher on normal tissue. Do not use around the eyes. Makes wounds smell better.

ATLS Hemorrhage Classification

For a 70kg male

Estimated Blood Loss Based on Patient's Initial Presentation				
Parameter	Class I	Class II	Class III	Class IV
Blood loss (ml)	Up to 750	750-1500	1500-2000	>2000
Blood loss (% blood volume)	Up to 15	15-30	30-40	>40
Pulse Rate (bpm)	<100	100-120	120-140	>140
Blood Pressure	Normal	Normal	Decreased	Decreased
Pulse Pressure (mmHg)	Normal or increased	Decreased	Decreased	Decreased
Respiratory Rate (breaths/min)	14-20	20-30	30-40	>35
Urine Output	>30	20-30	5-15	Negligible
CNS/Mental status	Slightly anxious	Mildly anxious	Anxious, confused	Confused, lethargic
Fluid replacement	Crystalloid	Crystalloid	Crystalloid and blood	Crystalloid and blood

Work/Rest and Water Consumption Table

Applies to average sized, heat-acclimated Soldier wearing ACU, hot weather. (See TB MED 507 for further guidance.)

Easy Work		Moderate Work		Hard Work	
Heat Category	WBGT Index, F°	Easy Work		Moderate Work	
		Work/Rest (min)	Water Intake (qt/hr)	Work/Rest (min)	Water Intake (qt/hr)
		NL	1/2	NL	3/4
		NL	1/2	50/10 min	1
		NL	3/4	40/20 min	1
Heat Category	WBGT Index, F°	Easy Work		Moderate Work	
		Work/Rest (min)	Water Intake (qt/hr)	Work/Rest (min)	Water Intake (qt/hr)
		NL	1	20/40 min	1
		50/10 min	1	10/50 min	1
		> 90°			

Easy Work	Moderate Work	Hard Work

- The work/rest times and fluid replacement volumes will sustain performance and hydration for at least 4 hrs of work in the specified heat category. Fluid needs can vary based on individual differences ($\pm \frac{1}{2}$ qt/hr) and exposure to full sun or full shade ($\pm \frac{1}{2}$ qt/hr).
- NL = no limit to work time per hr.
- Rest = minimal physical activity (sitting or standing) accomplished in shade if possible.
- **CAUTION: Hourly fluid intake should not exceed $1\frac{1}{2}$ qts.**
Daily fluid intake should not exceed 12 qts.
- If wearing body armor, add 5°F to WBGT index in humid climates.
- If doing Easy Work and wearing NBC (MOPP 4) clothing, add 10°F to WBGT index.
- If doing Moderate or Hard Work and wearing NBC (MOPP 4) clothing, add 20°F to WBGT index.

Temperature (°F)

Relative Humidity (%)	Temperature (°F)															
	80	82	84	86	88	90	92	94	96	98	100	102	104	106	108	110
40	80	81	83	85	88	91	94	97	101	105	109	114	119	124	130	136
45	80	82	84	87	89	93	96	100	104	109	114	119	124	130	137	
50	81	83	85	88	91	95	99	103	108	113	118	124	131	137		
55	81	84	86	89	93	97	101	106	112	117	124	130	137			
60	82	84	88	91	95	100	105	110	116	123	129	137				
65	82	85	89	93	98	103	108	114	121	128	136					
70	83	86	90	95	100	105	112	119	126	134						
75	84	88	92	97	103	109	116	124	132							
80	84	89	94	100	106	113	121	129								
85	85	90	96	102	110	117	126	135								
90	86	91	98	105	113	122	131									
95	86	93	100	108	117	127										
100	87	95	103	112	121	132										

Likelihood of Heat Disorders with Prolonged Exposure or Strenuous Activity

Caution Extreme Caution Danger Extreme Danger

Temperature (°F)



Frostbite Times  30 minutes  10 minutes  5 minutes

$$\text{Wind Chill (°F)} = 35.74 + 0.6215T - 35.75(V^{0.16}) + 0.4275T(V^{0.16})$$

Where, T= Air Temperature (°F) V= Wind Speed (mph)

Water treatment while hiking, camping, and traveling

When visiting places with unknown water quality, you may need to treat water to make sure it's safe to drink. **Boiling water is the most reliable way to kill germs.** If you cannot boil your water, the next best option is to use a filter (especially if water is cloudy) and then use another treatment method. Follow instructions on the treatment product's label, including the contact time for disinfectants. This guide can help you decide which treatment method or combination of methods to use to make your water safe to drink.

	 BOIL (for 1 min., or 3 mins. at elevations above 6,500 feet)	 FILTER	 PURIFIER	 CHLORINE TREATMENT (disinfectant)	 IODINE (disinfectant)	 CHLORINE DIOXIDE (disinfectant)	 COMBINING FILTER AND DISINFECTANT	 UV LIGHT USED IN CLEAR WATER	
BACTERIA (such as <i>Campylobacter</i> , <i>Salmonella</i> , <i>Shigella</i> , <i>E. coli</i>)	✓	✓ 0.3 micron or smaller filter	✓	✓	✓	✓	✓ 0.3 micron or smaller filter, plus disinfectant	✓	
VIRUSES (such as norovirus, hepatitis A, enterovirus, rotavirus)	✓	✗	✓	✓	✓	✓	✓	✓	
PARASITE <i>Giardia</i>	✓	✓ Filter certified for "cyst" and "oocyst" reduction	✓	!	!	✓	✓ Filter certified for "cyst" and "oocyst" reduction, plus chlorine dioxide	✓	
PARASITE <i>Cryptosporidium</i>	✓	✓ Filter certified for "cyst" and "oocyst" reduction	✓	✗	✗	!	✓ Filter certified for "cyst" and "oocyst" reduction, plus chlorine dioxide	✓	



**Centers for Disease
Control and Prevention**
National Center for Emerging and
Zoonotic Infectious Diseases

Learn more: www.cdc.gov/healthywater/drinking/travel/backcountry_water_treatment.html

✓ **EFFECTIVE**—will remove or kill this type of germ

! **SOMEWHAT EFFECTIVE**—may remove some germs of this type, but water could still be unsafe

✗ **NOT EFFECTIVE**—will not remove or kill this type of germ

SODIS

Solar Water Disinfection

SODIS is a cheap method to treat drinking water in your household. Fill clear water into a transparent plastic bottle and expose it to sunlight for 1 day, or 2 days in cloudy weather. The sunlight kills the germs in the water and makes it safe for you to drink!

**My Choice for
Safe Water!**

SODIS Application



Use a clean plastic bottle that is...

- ✔ transparent
- ✔ 3 litres max.

1



Wash the bottle well the first time you use it

2

Fill the bottle with clear water up to the brim



3

Expose the bottle to sunlight for...

1 full day
in clear
weather



2 consecutive days
in cloudy
weather



4



Enjoy your safe SODIS water!

The SODIS method

The SODIS method is a water disinfection method, making use of the sun's energy and using PET bottles. It exploits the germicidal effect of solar radiation – especially UV-A radiation – on diarrhoea causing pathogens.

The SODIS method consists of the following simple steps:

1. Wash a plastic bottle: The bottle must be clean, transparent, colourless, 2l in volume or smaller, and have all plastic or paper labels removed. We recommend using PET bottles and to wash them with soap before the first usage.

2. Fill bottle with water: Potentially contaminated water is filled into a PET bottle. The water should not be very turbid.

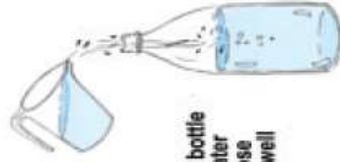
3. Expose bottle to the sun: The bottle is exposed to direct sunlight for one full day (at least 6 hours including noon hours) on mostly sunny days, or 2 days when the sky is more than 50% clouded. On days of continuous rainfall, SODIS should not be used.

4. Store water: The treated water is stored in the bottles until consumption in order to avoid re-contamination.

1 Wash the bottle well the first time you use it



2



Fill the bottle with water and close the lid well

4

The water is now ready for consumption

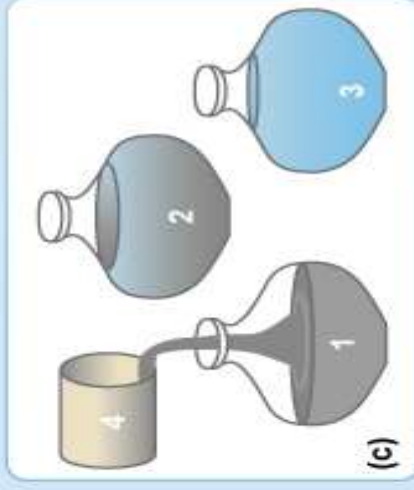
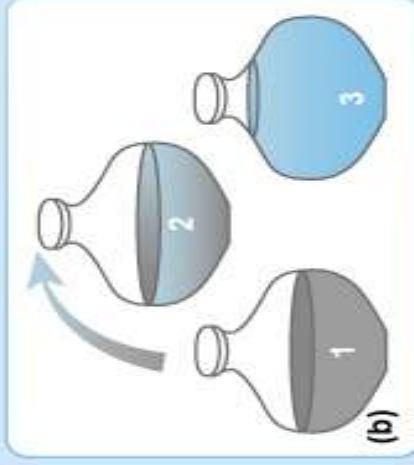
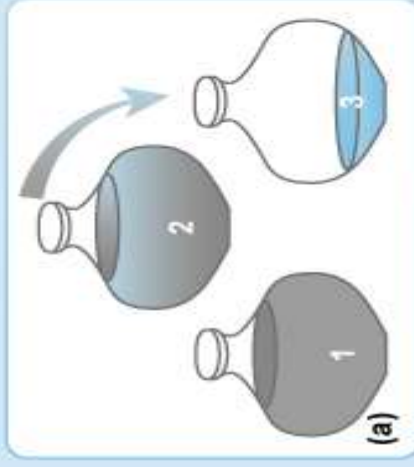


3

Expose the bottles to the sun morning to evening for at least 6 hours



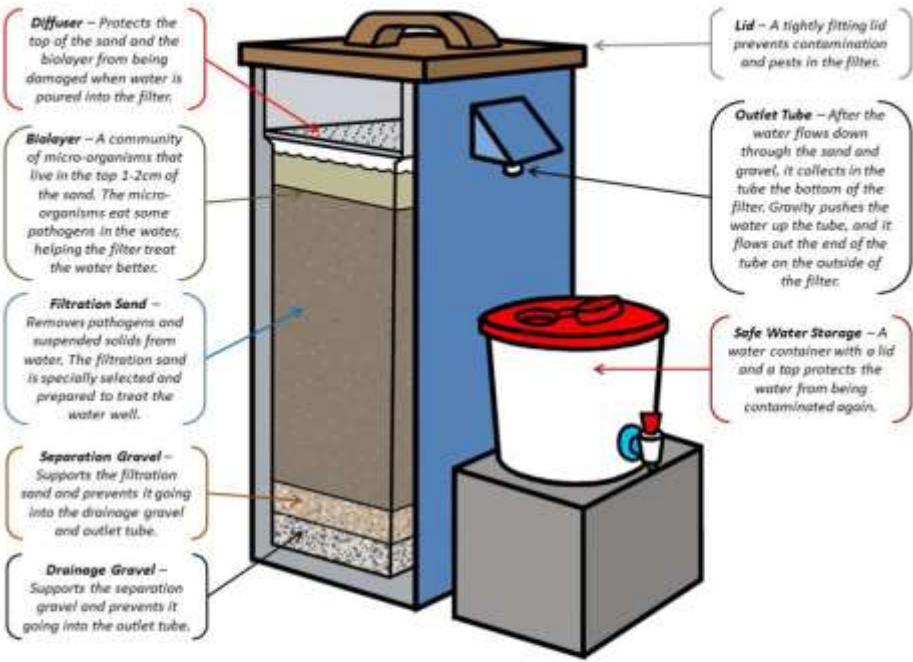
The three-pot treatment system



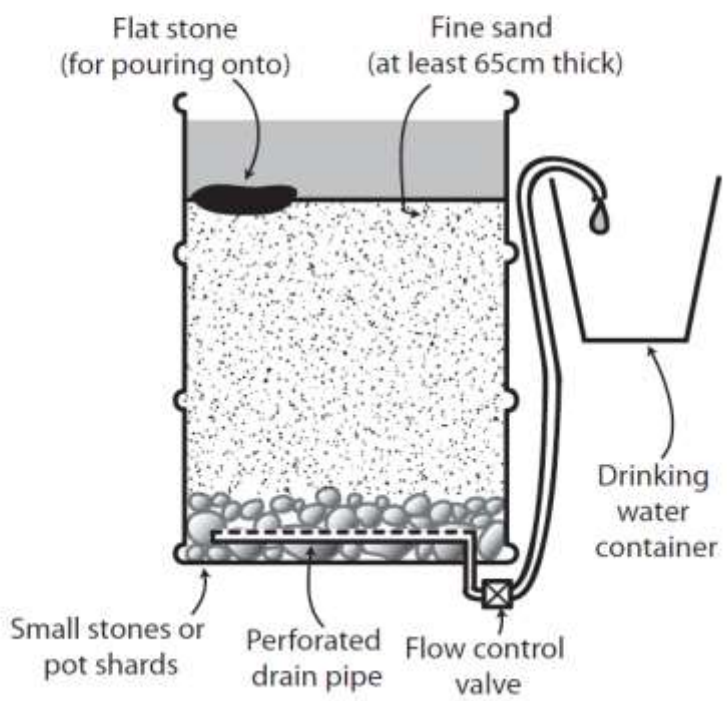
Drinking-water: always take from pot 3. This water has been stored for at least two days, and the quality has improved. Periodically this pot will be washed out and may be sterilized by scalding with boiling water.

Each day when new water is brought to the house:

- Slowly pour water stored in pot 2 into pot 3. Wash out pot 2.
 - Slowly pour water stored in pot 1 into pot 2. Wash out pot 1.
 - Pour water collected from the source (bucket 4) into pot 1. You may wish to strain it through a clean cloth.
- Using a flexible pipe to siphon water from one pot to another disturbs the sediments less than pouring.



Slow sand filter



> Sand filters

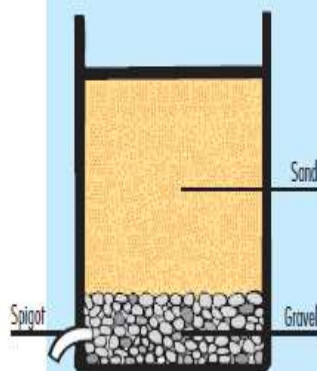
> Pre-treatment

Filtration through sand is a fast and simple pre-treatment option that reduces the amount of dirt in water and makes disinfection more effective.

Users pour water from one container through a container of sand with gravel and an opening or spigot at the bottom. The water then flows into a storage container.

Pre-treatment through sand has positive and negative aspects.

- ▲ This method is simple and fast to use.
- ▲ It is effective at removing dirt and some germs that cause disease.
This can make the other methods of treating water work better.
- ▲ It is inexpensive if the sand and containers are available locally
- It requires three containers and a spigot.



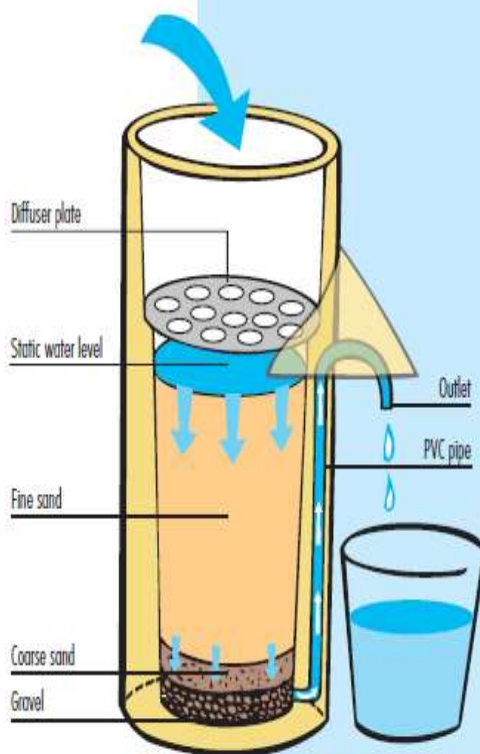
> Biosand filters

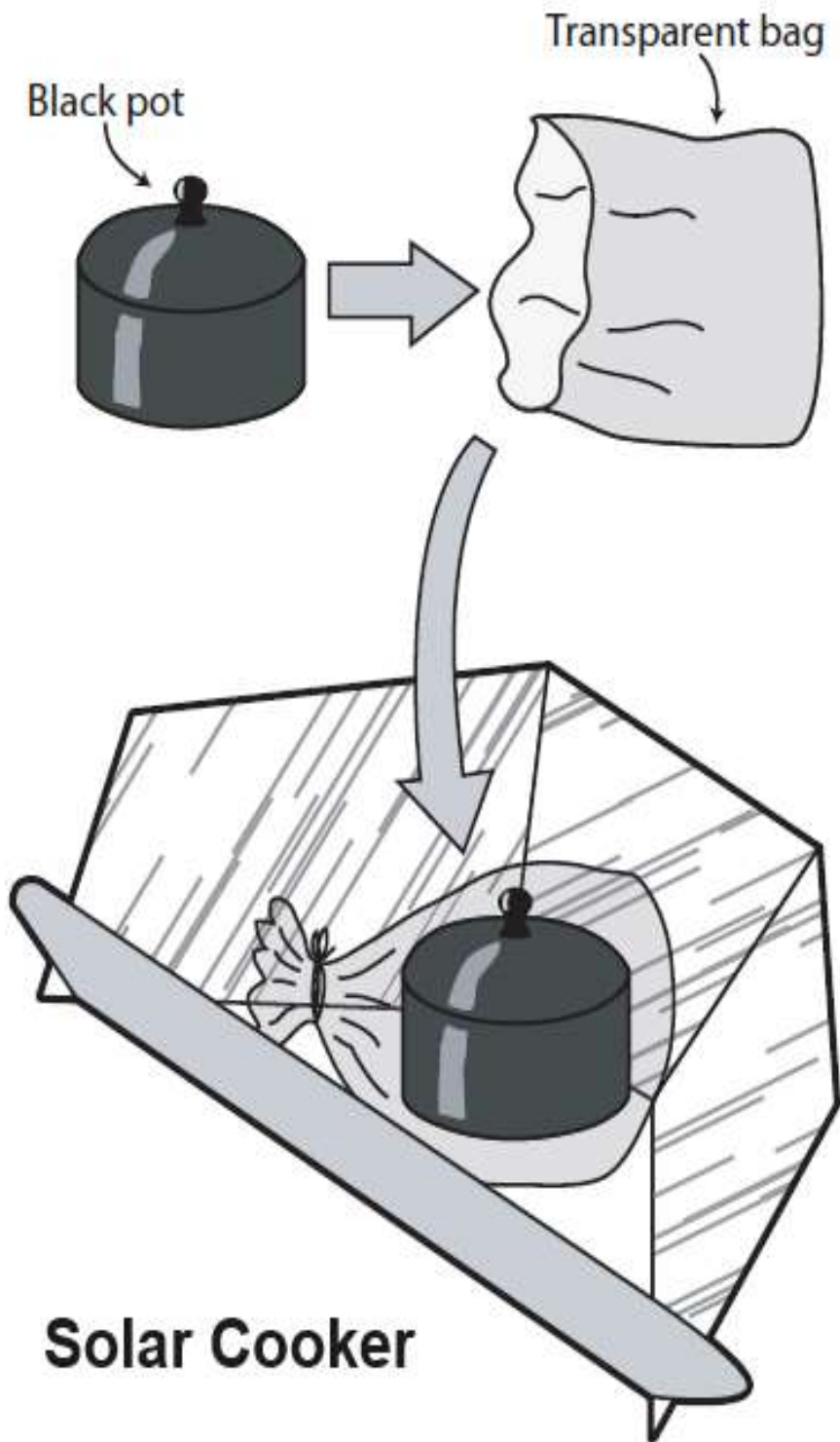
Although not commonly used in emergencies, biosand filters are an effective and long lasting method of household water treatment. Biosand filters filter water through the sand AND the biological material that grows on the top of the filter. The filter is cleaned when it becomes clogged.

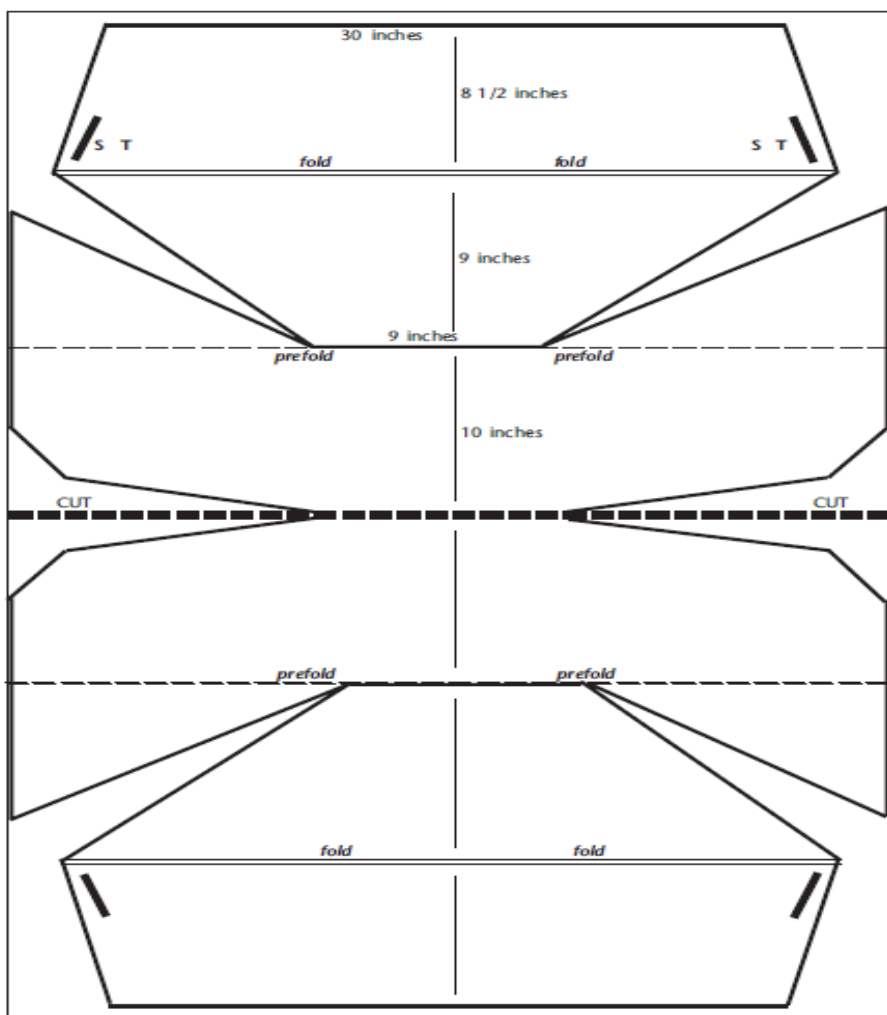
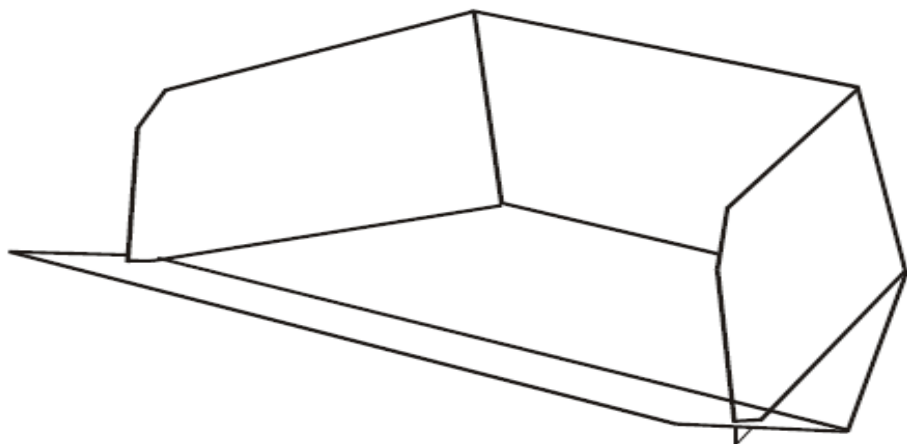
Because the biological layer needs time to grow, the filter will not treat properly when it is first put into use and after cleanings.

Although these filters are simple to use, they require hands on training when they are distributed. Details on construction and maintenance of these filters can be found in Additional resources.

- ▲ If properly maintained, this filter can treat water for a long time
- It can take a great deal of time to treat water, especially when the water is very dirty.
- There is no residual effect of disinfection, the clean water container must be covered to protect against contamination.
- These filters need regular maintenance and require more training and follow up.







Soda Can Stove

You can make different kinds of stoves from materials found around the home. A soda can stove, made from three soda pop cans and rubbing alcohol, can be used indoors or outdoors to cook small amounts of food. It's light-weight and great for back-packers and in emergency kits.

Supplies:

- 3 standard soda pop cans
- Denatured or rubbing alcohol
- Matches or lighter
- 1" x 1.5" x 5" swath of fiberglass insulation (optional)
- Heat resistant foil tape (optional)

Tools:

- Drill
- 1/8" & 1/16" drill bits
- Utility knife
- Scissors
- Straight edge
- Ruler
- Marking pen

Instructions:

1. Score the bottom of one can with the utility knife until it easily pops out.



2. Drill 1/16 inch holes spaced evenly around the bottom ring of the can for the burner. Drill one 1/8 inch hole as a drain for leftover fuel.

3. Using scissors, cut around the edge of the drilled end of the can until it is one inch high all the way around. This is the top of the stove. Cut another one inch base from a second can. This is the bottom of the stove.



4. On the top can, cut slits up from the bottom, stopping 1/8 inch from the top. This piece will now fit inside the bottom can with some careful pressure.



5. Carefully slide top and bottom pieces temporarily together. Measure from top to bottom (between the arrows) to get the width of the inner shield.



6. Use a straight edge and utility knife to cut a strip from the third can to the width measured in Step 5.



7. Place the inner shield into the base of the stove to get the correct circular measurement. Then cut opposite slits and join the ends together forming a ring.



8. Cut about three notches on the bottom of the inner shield to allow fuel to flow into the outer ring.



9. Place the inner shield in the base. Place the optional fiberglass in the space between the inner shield and the outer wall of the base.



10. Slide the top half into the bottom half of the stove. Be careful to fit the inner shield into the inner lip of the top and bottom halves of the stove. If there is any over hang from the bottom half, crimp the edges over with your thumb or a screw driver. You may use the heat resistant foil tape to cover the seams between the top and bottom halves of the stove to help prevent leaks.

11. Completed stove.

Add no more than 2 ounces of alcohol to the center of the stove and light it. The stove lights promptly, so be careful. You won't see an alcohol flame in daylight. It takes about a minute for the alcohol to heat up and achieve an even burn out of the burner holes. Cover the stove with a larger can to put out the flame. To cook, support a pot of food or water 1.5 inches to 2 inches above the stove. One ounce of fuel lasts a little longer than 5 minutes, just long enough to boil 12 ounces of water.

Practice fire safety indoors and out. Have fire extinguishers ready.



✓ Make a Plan ✓ Get a Kit ✓ Be Informed ✓ Get Involved

For more preparedness information: BeReady.Utah.gov



Recipe for Oral Rehydration Solution

Instead of store bought rehydration or sports drink (such as Gatorade® for adults, teens and children over age 3) you can make your own oral re-hydration solution at home.

INGREDIENTS:

- 4 cups clean water
- 2 tablespoons of sugar
- 1/2 teaspoon of salt

Mix the 4 cups of clean water with 2 tablespoons of sugar and 1/2 teaspoon of salt. Mix it well but do not boil as this will concentrate the ingredients. If local health officials give a "Boil Water Order", boil the water first for 1 minute and then allow it to cool before adding the sugar and salt.

Recipe for Cereal-Based Oral Rehydration Solution (CBORS)

For children under 3 years, you can make this cereal-based oral rehydration solution at home.

INGREDIENTS:

- 2 cups of clean water
- 1/2 cup of instant baby rice cereal
- 1/4 level teaspoon table salt

Mix thoroughly, but do not boil as this will concentrate the ingredients. If local health officials give a "Boil Water Order", boil water first for 1 minute and then allow to it to cool before adding cereal and salt.

Notes: Use of homemade CBORS should be considered as a last option because of the chance for mixing mistakes, which could be a problem for infants. Children are also less likely to take cereal-based solutions than glucose-based solutions. However, when properly mixed and used, CBORS has been found to be as effective as Pedialyte in maintaining hydration and correcting both hypernatremia and hyponatremia. *Source: Pediatrics Vol 100 No. 5. November 1997, p e3, available at: <http://pediatrics.aappublications.org/cgi/content/full/100/5/e3>*

Homemade Oral Rehydration Solution Recipes

Base Beverage	Recipe	
Water	• 1 quart water • $\frac{3}{4}$ teaspoon table salt • 2 Tablespoons sugar • Optional: Crystal Light® to taste (especially lemonade or orange-pineapple flavors)	
Gatorade® G2	• 4 cups Gatorade® G2 (or one, 32 ounce bottle) • $\frac{3}{4}$ teaspoon table salt; if your patient will not drink this because it is too salty for them, try $\frac{1}{2}$ teaspoon of salt per 32 oz, as it is better not drinking it at all.	
Chicken Broth	• 4 cups water • 1 dry chicken broth cube • $\frac{1}{4}$ teaspoon table salt • 2 tablespoons sugar	OR • 2 cups liquid broth (not low sodium!) • 2 cups water • 2 tablespoons sugar
Tomato Juice	• 2 $\frac{1}{2}$ cups plain tomato juice (not V8 or bloody mary mix) • 1 $\frac{1}{2}$ cups water	
Cranberry Juice	• $\frac{3}{4}$ cup juice • 3 & $\frac{1}{4}$ cups water • $\frac{3}{4}$ teaspoons table salt	
Cereal-Based	• $\frac{1}{2}$ cup dry baby rice cereal, cooked • 2 cups water • $\frac{1}{4}$ teaspoon table salt • Combine ingredients and mix until well dissolved and smooth. Refrigerate. Solution should be thick, but pourable and drinkable.	

B.R.A.T. Diet

Bananas, Rice, Apple sauce and Toast

For the FIRST 8-12 HOURS, Clear liquids in small amounts (sips), frequently:

Gatorade
Chicken broth
Apple or pear juice
7-Up! Sprite (flat)
Gelatin
Herbal tea
Bouillon

For the NEXT 12-24 HOURS, if improved, you may add to the above:

Saltine crackers
White toast with jelly
Bananas
Plain white cooked rice
Cereal (bland, i.e. Cheerios)
Apple sauce
Canned peaches or pears
Clear soups (not cream soups) with very soft noodles

NEXT 24 HOURS, if improvement continues and your stools are formed and firm, you may add:

Boiled chicken
Lean beef (baked, broiled, or boiled)
Egg (poached or scrambled)
Cooked carrots, green peas, green beans, or baked potato (no skin)
NO broccoli, cabbage, Brussels sprouts, or beans

DO NOT EAT these foods until you have had either normal Bowel Movement's or no Bowel Movement for 24 hours:

Raw, fried, or spicy foods
Citrus fruits or juices
Bran/whole grains
Alcohol
Caffeinated beverages
Candy
Dairy

If your stools continue to be firm, you may gradually return to your regular diet.

Milk and dairy products should be the last foods added.

BRAT Diet

Nutrition for Nausea, Vomiting or Diarrhea

Nutrition for nausea, vomiting or diarrhea consists of foods that are bland and gentle on the stomach. If you have nausea or vomiting, it may be hard to hold down food. Some foods may even make your symptoms worse. If you are experiencing diarrhea, the diet suggested below may help solidify your stools.

You may have heard of the BRAT diet which stands for **B**ananas, **R**ice, **A**pples, and **T**oast. The BRAT diet was often recommended for nausea, vomiting and diarrhea, but is no longer because of how restrictive it is. Below are lists of foods to focus on and avoid when experiencing nausea, vomiting or diarrhea, but there are many more foods that can be included.

FOODS TO FOCUS ON

- Soft fruits: bananas, applesauce, avocado, pumpkin, canned fruit (packed in water not heavy syrup), and melons
- Steamed or boiled vegetables: carrots, green beans, potatoes, and squash
- Low-fiber starches: white bread, white rice, saltine crackers, cream of wheat, instant oatmeal, and noodles
- Unseasoned skinless baked chicken or turkey, scrambled eggs, yogurt and kefir
- Drinks: bone broth, apple juice, coconut water, Pedialyte, weak tea
- **Homemade oral rehydration solution to prevent dehydration: 1 Liter of clean or boiled water, mix in 1/2 teaspoon of salt and 6 teaspoons of sugar and stir until both salt and sugar are completely dissolved. Cool down the water to room temperature or cooler before drinking.**

FOODS TO AVOID

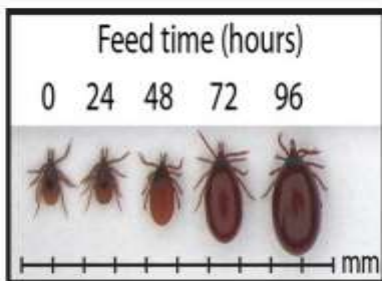
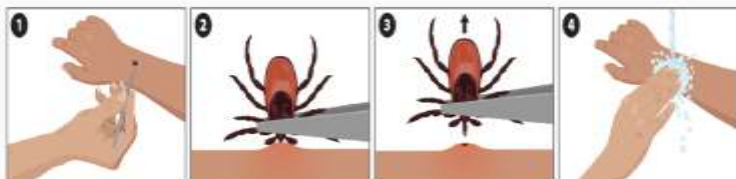
- Avoid milk and dairy products for three days. Yogurt and kefir are okay
- Avoid fried, fatty, greasy and spicy foods
- Avoid pork, veal, salmon, and sardines
- Avoid raw vegetables such as parsnips, beets, sauerkraut, corn on the cob, cabbage, broccoli, cauliflower, and onions
- Avoid citrus fruits: pineapples, oranges, grapefruits, lemons and limes
- Other fruits to avoid: tomatoes, cherries, grapes, figs, raisins, and seeded berries
- Avoid extremely hot or cold beverages
- Avoid alcohol
- Avoid coffee and caffeinated sodas
- Avoid added sugars and sweets like candy, soda and most juice

Tick Bite: What to Do

Tick bites can make people sick. Below are some steps that you can take after a tick bite to reduce your chances of getting sick and how to get treatment promptly if you do get sick.

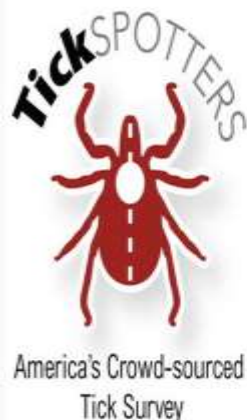
Remove the tick as soon as possible

1. Use fine-tipped tweezers to grasp the tick as close to the skin as you can.
2. Pull upward with steady, even pressure. Don't twist or jerk the tick.
3. After removing the tick, clean the bite area and your hands with rubbing alcohol or soap and water.



Accurate tick information, expert guidance: Easy, Fast, Free

Our TickSpotters program provides users with accurate, timely tick identification information, as well as science-based risk assessments tailored to their tick. Submit your own tick photo and get a free tick ID by a tick expert along with guidance on best next actions to lessen your risk of future tick bites and tickborne disease. <https://web.uri.edu/tickencounter/>



Brown Recluse Spiders



The brown recluse spider has a distinctive violin-shaped pattern on the back of its front body section. At first, the bite may produce little or no pain. Pain in the area of the bite develops an hour or more later. A blood-filled blister forms under the surface of the skin, sometimes in a target or bull's-eye pattern. Over several hours, the blister increases in size and eventually ruptures, leading to tissue destruction and a black scab.

What to Look For

Signs and symptoms of spider bites depend on the amount of venom injected and the person's sensitivity to the venom. Most spider bites heal with no adverse effects or scarring. Signs and symptoms of venomous spider bites can seem identical to those of other conditions and therefore can be difficult to recognize. The only way for a First Aider to be certain that a venomous spider has bitten a person is to have witnessed it.

Brown Recluse Spider Bite

Signs and symptoms of a brown recluse spider bite include the following:

- A slight stinging sensation (though bites may not be initially felt)
- A blood-filled blister that appears within 2 to 8 hours
- A bull's-eye pattern around the bite

Signs and symptoms of a severe reaction to a brown recluse spider bite occur within 72 hours of the bite and include nausea, vomiting, and joint pain.

Black Widow Spiders



The black widow spider is black with a reddish hourglass shape on the underside of its body. Its bite is the most painful and deadly of all the widow spiders, especially for very young children and older adults. The bite usually causes an immediate, sharp, "pin-prick" pain, followed by dull pain in the area of the bite. However, the person often does not know that he or she has been bitten until he or she starts to feel ill or notices a bite mark or swelling.

The signs and symptoms of a black widow spider bite (e.g., abdominal cramps), can mimic those of other medical emergencies. Anyone with a suspected bite should be seen by a doctor for correct diagnosis and treatment.

Black Widow Spider Bite

Signs and symptoms of a black widow spider bite include the following:

- A raised, round, red mark
- Cramping pain in the thighs, shoulders, back, and abdominal muscles
- Restlessness and anxiety
- Dizziness
- Headache
- Excessive sweating
- Weakness

Venomous Snakes

Rattlesnakes



Copperheads



Cottonmouths/Water Moccasins



Coral Snakes



Signs of Snake Bite



RASH-CAUSING PLANTS

When there is the potential for exposure to rash-causing plants, follow these guidelines:

- Wear a long-sleeved shirt, long pants, and closed-toed shoes.
- Apply a pre-contact barrier cream or lotion before going outside.
- Wash skin with a specialized skin cleanser designed to remove plant oils or a degreasing soap (such as dishwashing liquid) and plenty of water immediately after returning indoors.
- Wash tools, work gloves, and clothing that may have contacted rash-causing plants, as oils can remain on these items and transfer to the skin the next time they are used.

If you suspect that your skin has come into contact with a rash-causing plant, wash the entire area with a degreasing soap immediately.

Poison Ivy



Poison Oak



Poison Sumac



Giant Hogweed



Wild Parsnip



EpiPen Auto-Injector

1

Form fist around **EpiPen®** and **PULL OFF BLUE SAFETY CAP.**



Check the EXPIRY DATE on your EpiPen.

Always carry TWO EpiPens with you.

Possible side effects after the use of an EpiPen injection.

2

POSITION ORANGE END about 10cm away from outer mid-thigh*.

* Either clothed, or unclothed, avoiding seams and pocket areas.



- Headache.
- Nausea and vomiting.
- Feeling weak.
- Dizziness.
- Paleness.
- Sweating.
- Anxiety and nervousness.
- Shaking, usually of the hands (tremor).
- Awareness of your heartbeat (palpitations).
- Faster than normal heartbeat (tachycardia).
- Abnormal heart beats (arrhythmias).
- Difficulty breathing.

3

SWING AND JAB ORANGE TIP into thigh at 90° angle and hold in place for 10 seconds.



Know your EpiPen.

4

REMOVE EpiPen®
Massage injection site for 10 seconds*.

*After use the orange needle cover automatically extends to cover the injection needle.



EPIPEN® (YELLOW)

FOR CHILDREN AND
ADULTS WEIGHING OVER
25KG

EPIPEN® JR (GREEN)

FOR CHILDREN
WEIGHING BETWEEN
7.5-25KG

Viruses or Bacteria

What's got you sick?

Antibiotics are often prescribed when they are not needed for respiratory infections.

Antibiotics are only needed for treating certain infections caused by bacteria. Viral illnesses cannot be treated with antibiotics. When an antibiotic is not prescribed, ask your healthcare professional for tips on how to relieve symptoms and feel better.

Common Respiratory Infections	Common Cause			Are Antibiotics Needed?
	Virus	Virus or Bacteria	Bacteria	
Common cold/runny nose	✓			No
Sore throat (except strep)	✓			No
COVID-19	✓			No
Flu	✓			No
Bronchitis/chest cold (in otherwise healthy children and adults)*		✓		No*
Middle ear infection		✓		Maybe
Sinus infection		✓		Maybe
Strep throat			✓	Yes
Whooping cough			✓	Yes

* Studies show that in otherwise healthy children and adults, antibiotics for bronchitis won't help patients feel better.

REVERSE OPIOID OVERDOSE WITH NALOXONE



What is naloxone?

Naloxone is a life-saving medication that can reverse an overdose from opioids—including heroin, fentanyl, and prescription opioid medications—when given in time.¹ Naloxone is easy to use and small to carry. There are two forms of naloxone that anyone can use without medical training or authorization: prefilled nasal spray and injectable.



Nasal Spray

Prefilled devices that spray medication into the nose.



Injectable

Medication (solution) given by injection into a muscle or under the skin.

The decision on which form of naloxone to use or carry can depend many factors such as cost, availability, and comfort level. Both are safe, effective, and can help save a life.



Naloxone is a highly effective opioid overdose-reversing drug that saves thousands of lives in the United States. By taking universal safety precautions, all law enforcement, firefighters, and EMS providers can safely administer [naloxone for overdose reversal](#), even during the COVID-19 pandemic.

Steps to respond to a suspected opioid overdose while reducing risk of COVID-19 exposure:

- 1 Use Personal Protective Equipment (PPE) such as gloves and face protection, as most first responders are doing for all emergency calls during the COVID-19 pandemic.

If the person is suspected or confirmed to have COVID-19 or if you see illicit drugs in powder or liquid form, put on additional PPE as recommended by CDC.
- 2 If possible, position the person's head facing away from you.
- 3 Administer naloxone following the instructions for use (the Evzio auto-injector provides voice instructions).
- 4 Start other life support measures if needed and if trained to do so, using appropriate precautions if the person is suspected or confirmed to have COVID-19.
- 5 Stand up and step back to a distance of at least 6 feet as the person regains consciousness.
- 6 Assess the person, introduce yourself, and explain to them what led to naloxone administration, effects of naloxone, and importance of seeking follow-up care.
- 7 When safe, remove PPE following appropriate safety procedures. Avoid touching your eyes, nose, and mouth.
- 8 Wash your hands with soap and water for at least 20 seconds. If soap and water are not available and you had no skin contact with illicit drugs, use an alcohol-based hand sanitizer with at least 60% alcohol.

Assess your safety when you arrive on the scene.

Before you leave, make sure the person receives professional medical follow-up.

HHS encourages the use of PPE while administering all forms of naloxone.

MEDICATIONS FOR OPIOID OVERDOSE, WITHDRAWAL, & ADDICTION

Medications for opioid **overdose**, **withdrawal**, and **addiction** are safe, effective, and save lives.

The National Institute on Drug Abuse supports research to develop new medicines and delivery systems to treat opioid use disorder and other substance use disorders, as well as other complications of substance use (including withdrawal and overdose), to help people choose treatments that are right for them.

Medications approved by the U.S. Food and Drug Administration for opioid addiction, overdose, and withdrawal work in various ways.

Opioid Receptor Agonist

Medications attach to opioid receptors in the brain to block withdrawal symptoms and cravings.

Opioid Receptor Partial Agonist

Medications attach to and partially activate opioid receptors in the brain to ease withdrawal symptoms and cravings.

Opioid Receptor Antagonist

Medications attach to and block activity of opioid receptors in the brain. Antagonist medications that treat substance use disorders do so by preventing euphoric effects (the high) of opioids and alcohol and by reducing cravings. Antagonist medications used to treat opioid overdoses do so by reversing dangerous drug effects like slowing or stopping breathing.

Adrenergic Receptor Agonist

A medication that attaches to and activates adrenergic receptors in the brain and helps alleviate withdrawal symptoms.

REDUCES OPIOID USE AND CRAVINGS

Methadone

Daily liquid or tablet

Naltrexone

Monthly injection

Buprenorphine

Daily tablet
Weekly or monthly injection

Buprenorphine/ Naloxone

Daily film under the tongue or tablet

Naloxone

Emergency nasal spray or injection

Nalmefene

Emergency nasal spray or injection

Lofexidine

As-needed tablet

TREATS WITHDRAWAL SYMPTOMS

REVERSES OVERDOSE

MARIJUANA

THE RISKS ARE REAL

Using marijuana carries real risks for your health and quality of life. Some might be surprising to you. So know the risks — learn before you burn, eat, or use.

Today's marijuana is stronger.

Today's marijuana has more than **3 times** the concentration of THC than marijuana from 25 years ago. More THC — the mind-altering chemical in marijuana — may lead to an increase in dependency and addiction.



Risk of addiction.

About **1 in 10** people who use marijuana may become addicted to marijuana — and **1 in 6** when use begins before age 18.

Lowers brain power.

Marijuana affects your brain development. Use by adolescents has been linked to a decline in IQ scores — up to 8 points! Those are points you don't get back, even if you stop using.



Impairs your memory.



Using marijuana can affect your memory, learning, concentration, and attention. Other effects include difficulty with thinking and problem solving.

Affects your performance.



Using marijuana can lead to worse educational outcomes. Compared with teens who don't use, students who use marijuana are more likely not to finish high school or get a college degree.

Can harm your baby.



Using marijuana when you're pregnant can affect your baby's development. It's linked to lower birth weight, preterm birth and stillbirth, increased risk of brain and behavioral problems.

Driving danger.

People who drive under the influence of marijuana can experience dangerous effects: slower reactions, lane weaving, decreased coordination, and difficulty reacting to signals and sounds on the road.

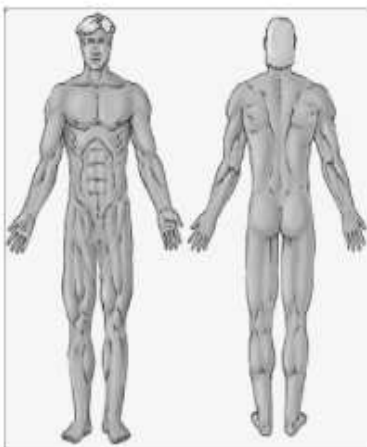


Marijuana use comes with real risks. Learn more at [SAMHSA.gov/marijuana](https://www.samhsa.gov/marijuana)

oxygen therapy



						
	Nasal cannula	Simple face mask	Reservoir mask	Nasal high flow	CPAP	Ventilator
	Low oxygen flow	Moderate oxygen flow	High oxygen flow	Very high oxygen flow	Specialised form of pressure positive ventilation.	Invasive form of pressure positive ventilation.
	For regular hospital and home care.	For regular hospital and home care.	For hospital care.	Used in situations of respiratory failure.	Can be used for patients with apnea or to maintain an open airway.	Required when a patient's lungs are severely impaired.
OXYGEN FLOW	1-6 Litres/min	5-10 Litres/min	15 Litres/min	UP TO 70 Litres/min	15 Litres/min	AS PER LIFE SUPPORT NEEDS
FI _{O2} * FRACTION OF INSPIRED OXYGEN	24-50%	40-60%	60-90%	UP TO 100%	UP TO 100%	UP TO 100%

PATIENT IDENTIFICATION		TRANSPORT INFORMATION		HISTORY	
Name:	Service:	Date:	On Scene:	S/S:	
SSN:	Rank:	Incident:	Recovered:	ALLERGIES: LMP:	
DOB:	Age:	Alert:	Delivered:	MEDICATIONS:	
Unit:	Sex:	Launch:	MTF:		
☐ U.S. Military ☐ U.S. Civilian ☐ Non-U.S. Mil ☐ Non-U.S. Civ ☐ EPW					
MECHANISM OF INJURY/CHIEF COMPLAINT/TRANSFER PATIENT DIAGNOSIS					
AIRWAY Assessment: Treatment:		BREATHING Assessment: Treatment:		CIRCULATION Assessment: Treatment:	
☐ Patent/Normal OPA: NPA: ☐ Obstructed ETT Size: NT Size: ml Other: Suction:		☐ Adequate ☐ NRB ☐ Inadequate ☐ NC ☐ Bilateral ☐ BVM ☐ R ☐ L ☐ Ventilator ☐ Absent O ₂ LPM Other:		Pulse: ☐ Normal ☐ Weak ☐ ECG: ☐ Bounding ☐ Absent ☐ CPR: Skin: ☐ Hot ☐ Warm ☐ Dry ☐ Cool ☐ Moist Bleeding: ☐ None ☐ Uncontrolled ☐ Dressing ☐ Controlled ☐ Quick Clot ☐ Tourniquet Shock: ☐ Position ☐ Blankets ☐ IV ☐ P.A.S.G.	
GLASGOW COMA SCALE					
Eye Opening ☐ 4 - Spontaneous ☐ 3 - To Command ☐ 2 - To Pain ☐ 1 - None GCS Total:		Verbal Activity ☐ 5 - Oriented ☐ 4 - Confused ☐ 3 - Inappropriate ☐ 2 - Incomprehensible ☐ 1 - None Time:		Motor Activity ☐ 6 - Obeys Command ☐ 5 - Localized Pain ☐ 4 - Withdraws to Pain ☐ 3 - Flexion to Pain ☐ 2 - Extension to Pain ☐ 1 - None	
GCS Total: Time: CID/Spine Immobilization Type:					
VITAL SIGNS				MEDICATION	
TIME:					
BP:					
PULSE:					
RESP:					
S _{PO2} %:					
TEMP:					
ECG:					
NARRATIVE				1. Deformities 5. Burns 9. IV/Hop-lock 2. Confusions 6. Tenderness 10. GSW 3. Abrasions 7. Lacerations 11. Amputation 4. Puncture 8. Swelling 12. Sutures/Staples	
					
				APPROXIMATE WEIGHT (lbs/Kg): Weight in lbs Divided by 2.2 = Weight in Kg	
SMT/PROVIDER		RECEIVING FACILITY		IV THERAPY	
Name:		Transfer Doctor:		IV	1
Rank:		Receiving Doctor:		TIME	2
SAR/IVAC Unit:		Pt. Received By:		SITE	
Signature:		Signature:		SIZE	
Report Serial#:		Time Flown:		TYPE	
Call Sign:		ACFT#:		RATE	
HAC:		CC:		mL	
				PAIN SCALE (1-10)	
				TIME	PAIN



Trauma Care Checklist

Immediately after primary & secondary surveys:

IS FURTHER AIRWAY INTERVENTION NEEDED? May be needed if: • GCS 8 or below • Hypoxaemia or hypercarbia • Face, neck, chest or any severe trauma	☐ YES, DONE ☐ NO
IS THERE A TENSION PNEUMO-HAEMOTHORAX?	☐ YES, CHEST DRAIN PLACED ☐ NO
IS THE PULSE OXIMETER PLACED AND FUNCTIONING?	☐ YES ☐ NOT AVAILABLE
LARGE-BORE IV PLACED AND FLUIDS STARTED?	☐ YES ☐ NOT INDICATED ☐ NOT AVAILABLE
FULL SURVEY FOR (AND CONTROL OF) EXTERNAL BLEEDING, INCLUDING:	☐ SCALP ☐ PERINEUM ☐ BACK
ASSESSED FOR PELVIC FRACTURE BY:	☐ EXAM ☐ X-RAY ☐ CT
ASSESSED FOR INTERNAL BLEEDING BY:	☐ EXAM ☐ ULTRASOUND ☐ CT ☐ DIAGNOSTIC PERITONEAL LAVAGE
IS SPINAL IMMOBILIZATION NEEDED?	☐ YES, DONE ☐ NOT INDICATED
NEUROVASCULAR STATUS OF ALL 4 LIMBS CHECKED?	☐ YES
IS THE PATIENT HYPOTHERMIC?	☐ YES, WARMING ☐ NO
DOES THE PATIENT NEED (IF NO CONTRAINDICATION):	☐ URINARY CATHETER ☐ NASOGASTRIC TUBE ☐ CHEST DRAIN ☐ NONE INDICATED

Before team leaves patient:

HAS THE PATIENT BEEN GIVEN:	☐ TETANUS VACCINE ☐ ANALGESICS ☐ ANTIBIOTICS ☐ NONE INDICATED
HAVE ALL TESTS AND IMAGING BEEN REVIEWED?	☐ YES ☐ NO, FOLLOW-UP PLAN IN PLACE
WHICH SERIAL EXAMINATIONS ARE NEEDED?	☐ NEUROLOGICAL ☐ ABDOMINAL ☐ VASCULAR ☐ NONE
PLAN OF CARE DISCUSSED WITH:	☐ PATIENT/FAMILY ☐ RECEIVING UNIT ☐ PRIMARY TEAM ☐ OTHER SPECIALISTS
RELEVANT TRAUMA CHART OR FORM COMPLETED?	☐ YES ☐ NOT AVAILABLE



Medical Emergency Checklist

Immediately after primary & secondary surveys:

IS FURTHER AIRWAY INTERVENTION NEEDED? May be needed if: • Abnormal level of consciousness (AVPU scale) • Stridor • Respiratory Distress • Hypoxaemia or hypercarbia	☐ YES, DONE ☐ NO
IS THERE A SEVERE ALLERGIC REACTION? (ADRENALINE NEEDED)	☐ YES ☐ NO
IS THERE A TENSION PNEUMOTHORAX? (NEEDLE/DRAIN NEEDED)	☐ YES ☐ NO
DOES THE PATIENT NEED OXYGEN?	☐ YES ☐ NO
IS THE PULSE OXIMETER PLACED AND FUNCTIONING?	☐ YES ☐ NO
DOES THE PATIENT NEED BRONCHODILATORS? (e.g. salbutamol)	☐ YES ☐ NO
DOES THE PATIENT NEED IV FLUIDS?	☐ YES ☐ NO
ASSESSED FOR ONGOING BLEEDING (including gastrointestinal, vaginal, and other internal):	☐ BY EXAM ☐ NGT ☐ ULTRASOUND ☐ CT ☐ DIAGNOSTIC PERITONEAL LAVAGE
IS TREATMENT FOR HYPOGLYCAEMIA NEEDED?	☐ YES ☐ NO
IS TREATMENT FOR OPIOID OVERDOSE NEEDED?	☐ YES ☐ NO
IS THE PATIENT HYPOTHERMIC/HYPERTHERMIC?	☐ YES ☐ NO

When initial resuscitation is complete:

HAVE VITAL SIGNS BEEN RECHECKED?	☐ YES
HAS THE PATIENT BEEN GIVEN:	☐ ASPIRIN ☐ ANALGESIC ☐ TRANSFUSION ☐ ANTIBIOTICS ☐ NONE INDICATED
DOES THE PATIENT NEED AN ECG?	☐ YES ☐ NO
PREGNANCY TEST DONE?	☐ YES ☐ NOT INDICATED
HAVE ALL TESTS AND IMAGING BEEN REVIEWED?	☐ YES ☐ NO, PLAN IN PLACE
WHICH SERIAL EXAMS ARE NEEDED?	☐ NEUROLOGICAL ☐ ABDOMINAL ☐ VASCULAR ☐ RESPIRATORY ☐ NONE
PLAN OF CARE DISCUSSED WITH:	☐ PATIENT/FAMILY ☐ RECEIVING UNIT ☐ PRIMARY TEAM ☐ OTHER SPECIALISTS
RELEVANT EMERGENCY UNIT CHART COMPLETED?	☐ YES

*If intervention is needed but unavailable, respond YES and note missing item, date & time on stockout log sheet.

Universal Pain Assessment Tool

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

VERBAL DESCRIPTOR SCALE

0 1 2 3 4 5 6 7 8 9 10

NO PAIN

MILD PAIN

MODERATE PAIN

MODERATE PAIN

SEVERE PAIN

WORST PAIN POSSIBLE

WONG-BAKER FACIAL GRIMACE SCALE



Alert, smiling



No humor,
serious, flat



Furrowed brow,
pursed lips,
breath-holding



Wrinkled nose,
raised upper lips,
rapid breathing



Slow blink,
open mouth



Eyes closed,
moaning, crying

ACTIVITY TOLERANCE

NO PAIN

CAN BE IGNORED

INTERFERES WITH
TASKS/SLEEP

INTERFERES WITH
CONCENTRATION

INTERFERES WITH
BASIC NEEDS

BED REST REQUIRED

Acute Mountain Sickness (AMS)

- AMS is caused by ascending too rapidly to high altitude. Symptoms may include headache, nausea, vomiting, fatigue, irritability, insomnia, or dizziness.
- Symptoms generally appear four to 24 hours after ascent to high altitude, reaches peak severity in 24 to 48 hours, and subsides over three to seven days at the same altitude.
- To treat AMS, stop further ascent and descend. Continuing an ascent puts individuals at risk for more severe high-altitude illnesses.
- Once symptoms have gone away, troops can resume gradual ascent. Those who continue to show signs of AMS must be observed for development of high-altitude pulmonary edema or high-altitude cerebral edema, both of which could be fatal.
- All troops are susceptible to high-altitude illness. A staged or graded ascent that allows time for Soldiers to acclimate to altitude can help prevent AMS.

High-Altitude Pulmonary Edema (HAPE)

- HAPE occurs when individuals ascend too rapidly to high altitude or ascent too rapidly from a high to a higher altitude.
- HAPE normally begins within 24-72 hours after rapid ascent to 2,438 meters (8,000 feet) or more. Symptoms include coughing, noisy breathing, wheezing, gurgling in the airway, difficulty breathing when at rest, and deteriorated behavioral status (such as confusion or vivid hallucinations).
- Troops experiencing AMS who are not treated and continue to ascend to higher altitudes are at significant risk for HAPE. If untreated, HAPE can be fatal within six to 12 hours.
- Preventive measures include to drink plenty of water, eat regular meals high in carbohydrates, staged and graded ascent, proper acclimatization, sleeping at the lowest altitude possible, avoiding cold exposure, and avoiding strenuous exertion until acclimated.
- Immediate descent is the best treatment for HAPE.

High-Altitude Cerebral Edema (HACE)

- HACE is the most severe illness associated with high altitudes.
- In general, HACE occurs later than AMS or HAPE. If untreated, HACE can progress to coma in 12 hours and death within 24 hours. In some instances, death has occurred in less than 12 hours. The average onset time of symptoms following ascent is five days with a range of one to 13 days.
- Symptoms of HACE often resemble AMS (severe headache, nausea, vomiting, and extreme lethargy). However, a more visible indicator of the onset of HACE is a swaying upper body, especially when walking. Early behavioral deterioration may include confusion, disorientation, and inability to speak coherently.
- Preventive measures for HACE are the same as for AMS and HAPE. Troops with symptoms of HACE should be evacuated immediately.

LINE**ITEM****EVACUATION REQUEST MESSAGE**

1

Location of Pickup Site.

2

Radio Frequ., Call Sign, & Suffix.

3

No. of Patients by Precedence.

4

Special Equipment Required.

5

Number of Patients by Type.

6

Security of Pickup Site (Wartime).

6

Number and Type of Wound,
Injury, or Illness (Peacetime).

7

Method of Marking Pickup Site.

8

Patient Nationality and Status.

9

NBC Contamination (Wartime).

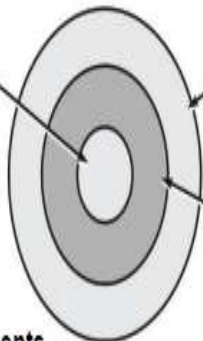
9

Terrain Description (Peacetime).

LINE ITEM	EXPLANATION
1. Location of Pickup Site.	Encrypt grid coordinates. When using <i>DRYAD Numeral Cipher</i> , the same <i>SET line</i> will be used to encrypt grid zone letters and coordinates. To preclude misunderstanding, a statement is made that grid zone letters are included in the message (unless unit SOP specifies its use at all times).
2. Radio Frequency, Call Sign, Suffix.	Encrypt the frequency of the radio at the pickup site, <i>not</i> a relay frequency. The call sign (and suffix if used) of person to be contacted at the pickup site may be transmitted in the clear.
3. No. of Patients by Precedence.	Report only applicable info & encrypt brevity codes. A = Urgent, B = Urgent-Surg, C = Priority, D = Routine, E = Convenience. (If 2 or more categories reported in same request, insert the word "break" btwn. each category.)
4. Spec Equipment.	Encrypt applicable brevity codes. A = None, B = Hoist, C = Extraction equipment, D = Ventilator.
5. No. of Patients by Type.	Report only applicable information and encrypt brevity code. If requesting MEDEVAC for both types, insert the word "break" between the litter entry and ambulatory entry: L + # of Pnt -Litter; A + # of Pnt - Ambul (sitting).
6. Security Pickup Site (Wartime).	N = No enemy troops in area, P = Possibly enemy troops in area (approach with caution), E = Enemy troops in area (approach with caution), X = Enemy troops in area (armed escort required).
6. Number and type of Wound, Injury, Illness (Peacetime).	Specific information regarding patient wounds by type (gunshot or shrapnel). Report serious bleeding, along with patient blood type, if known.
7. Method of Marking Pickup Site.	Encrypt the brevity codes. A = Panels, B = Pyrotechnic signal, C = Smoke Signal, D = None, E = Other.
8. Patient Nationality and Status.	Number of patients in each category need not be transmitted. Encrypt only applicable brevity codes. A = US military, B = US civilian, C = Non-US mil, D = Non-US civilian, E = EPW.
9. NBC Contamination, (Wartime).	Include this line only when applicable. Encrypt the applicable brevity codes. N = nuclear, B = biological, C = chemical.
9. Terrain Description (Peacetime).	Include details of terrain features in and around proposed landing site. If possible, describe the relationship of site to a prominent terrain feature (lake, mountain, tower).

HARD SURFACE:

Vegetation cut to 1 foot (.3M)
(will support aircraft)

**OBSTRUCTION FREE:**

Vegetation cut to 2 feet (.6M)

SURFACE CLEARED:

Vegetation cut to 1 foot (.3M)

Helicopter landing zone requirements

LANDING POINT	MINIMUM DIAMETER OF LANDING POINT	HARD SURFACE	SURFACE CLEARED	OBSTRUCTION FREE
SIZE 1 - Light Observation OH-58D OH-6 	25M	5M	15M	25M
SIZE 2 - Light Utility and Attack UH-1H H-65 AH-1W 	35M	10M	20M	35M
SIZE 3 - Medium Utility and Attack UH-60 H-2 AH-64 	50M	15M	35M	50M
SIZE 4 - Cargo 	80M	15M	35M	80M

Require Assistance	V
Require Medical Assistance or Unable to Proceed (old)	x
No or Negative	N
Yes or Affirmative	Y
Proceeding In This Direction	↑
We Have Found Only Some Missing Personnel	++
We are not able to continue; Returning to base.	XX
Nothing found. Will continue to search	NN
Require Firearm & Ammunition	V V
Require Doctor Serious Injuries	I
Require Medical Supplies	II
Require Food & Water	F
Indicate Direction to Proceed	K
Aircraft Seriously Damaged	☐
Fire Adequately Staffed	≡
Change Jump Spot (USFS)	J
Cargo Drop Target (USFS)	T
Helicopter Landing Spot	H
Need Cross-Cut Saw	S
Need Power Saw	
Need Climbers	O
Need Drinking Water	U
Need Radio with Batteries	R

Operation Completed	LLL
We Have Found All Missing Personnel	<u>LL</u>
All Well or Personnel OK	LL
Require Fuel & Oil or Jumper OK (USFS)	L
Not Understood	JL
Require Map & Compass	☐
Require Signal Lamp	
Will Attempt Takeoff	I>
Have divided into two groups. Each proceeding in direction indicated	↘
Information received that aircraft is in this direction	→→
Need Repairs or Require Engineer (old)	W
Probably Safe To Land Here	△
International Symbol of Distress	SOS
Able to Ride Horse	<u>2</u>
Need Stretcher Crew	<u>3</u>
Broken Leg	<u>4</u>
Broken Arm	<u>5</u>
Broken Back	<u>6</u>
Head Injury	<u>+</u>
Puncture Wound	<u>8</u>
Unable to Diagnose	<u>9</u>
Need Power Pump Outfit	PP
Need Batteries for Radio	RR

TACTICAL COMBAT CASUALTY CARE (TCCC) CARD

BATTLE ROSTER #: _____

EVAC: ☐ Urgent ☐ Priority ☐ Routine

NAME (Last, First): _____ **LAST 4:** _____

GENDER: ☐ M ☐ F **DATE** (DD-MMM-YY): _____ **TIME:** _____

SERVICE: _____ **UNIT:** _____ **ALLERGIES:** _____

Mechanism of Injury: (X all that apply)

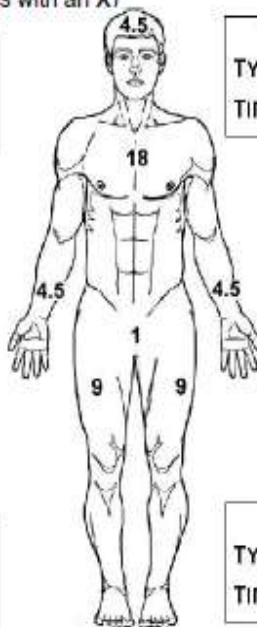
- ☐ Artillery ☐ Blunt ☐ Burn ☐ Fall ☐ Grenade ☐ GSW ☐ IED
☐ Landmine ☐ MVC ☐ RPG ☐ Other: _____

Injury: (Mark injuries with an X)

TQ: R Arm

TYPE: _____

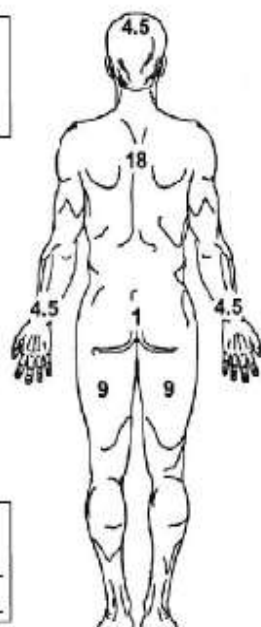
TIME: _____



TQ: L Arm

TYPE: _____

TIME: _____



TQ: R Leg

TYPE: _____

TIME: _____

TQ: L Leg

TYPE: _____

TIME: _____

Signs & Symptoms: (Fill in the blank)

Time

Pulse (Rate & Location)

Blood Pressure

Respiratory Rate

Pulse Ox % O2 Sat

AVPU

Pain Scale (0-10)

/	/	/	/	/

BATTLE ROSTER #: _____

EVAC: ☐ Urgent ☐ Priority ☐ Routine

Treatments: (X all that apply, and fill in the blank) *Type*

C: TQ- ☐ Extremity ☐ Junctional ☐ Truncal _____

Dressing- ☐ Hemostatic ☐ Pressure ☐ Other _____

A: ☐ Intact ☐ NPA ☐ CRIC ☐ ET-Tube ☐ SGA _____

B: ☐ O2 ☐ Needle-D ☐ Chest-Tube ☐ Chest-Seal _____

C:	Name	Volume	Route	Time
Fluid				
Blood Product				

MEDS:	Name	Dose	Route	Time
Analgesic (e.g., Ketamine, Fentanyl, Morphine)				
Antibiotic (e.g., Moxifloxacin, Ertapenem)				
Other (e.g., TXA)				

OTHER: ☐ Combat-Pill-Pack ☐ Eye-Shield (☐ R ☐ L) ☐ Splint

☐ Hypothermia-Prevention Type: _____

NOTES:

FIRST RESPONDER

NAME (Last, First): _____ **LAST 4:** _____



IFAK Generation II

National Stock No.	Item	No. Per Kit
6545-01-584-1582	U.S. Army IFAK	1
6515-01-521-7976	Combat Application Tourniquet	2
6510-01-492-2275	Bandage Kit, Elastic	1
6510-01-503-2117	Bandage, Gauze, 4 1/2 inch, 100s	1
6510-00-926-8883	Surgical Adhesive Tape, 2 inch, 6s	1
6515-01-180-0467	Nasopharyngeal Airway	1
6515-01-519-9161	Patient Exam Gloves, 100s	4
6510-01-562-3325	Dressing, Combat Gauze	1
4240-01-570-0319	Strap Cutter, Rescue	1
6510-01-549-0939	Bolin Chest Seal	1
6515-01-449-1016	Eye Shield, Fox	1
7520-00-312-6124	Marker, Tube Type	1

Wash Your Hands

During an emergency, keeping hands clean can help keep you and others healthy.



Washing hands with soap and clean water is the best way to remove germs that can make you and others sick. If you don't have soap and clean water, use an alcohol-based hand sanitizer that contains at least 60% alcohol.



Stay healthy by washing your hands many times each day:

BEFORE

- preparing food
- eating
- caring for someone who is sick
- treating a cut or a wound

AFTER

- Using the bathroom
- Changing diapers or cleaning a child who has used the toilet
- Blowing your nose, coughing, or sneezing
- Touching an animal, animal feed, or animal waste
- Handling pet food or pet treats
- Touching garbage



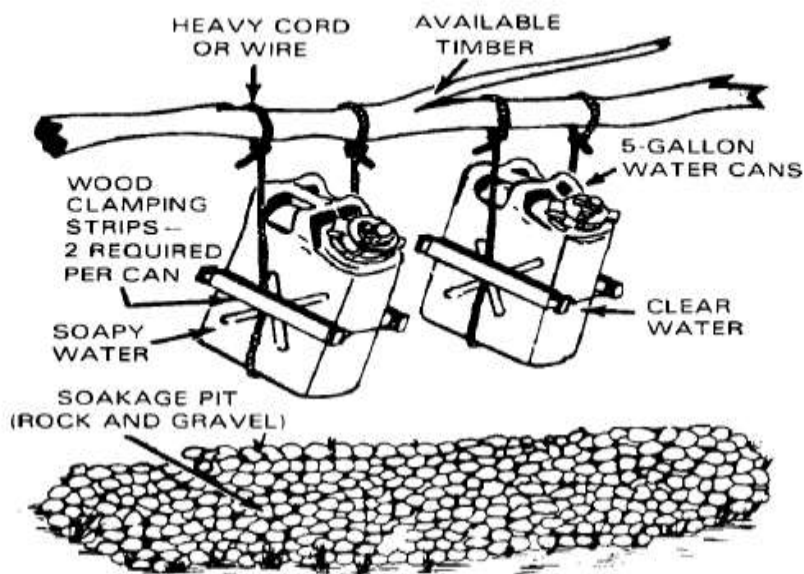
What is the right way to wash your hands?

1. Wet your hands with clean running water (warm or cold) and apply soap.
2. Lather your hands by rubbing them together with the soap.
3. Scrub all surfaces of your hands, including the palms, backs, fingers, between your fingers, and under your nails.
4. Keep scrubbing for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song twice.
5. Rinse your hands well under running water.
6. Dry your hands using a clean towel or air-dry them.

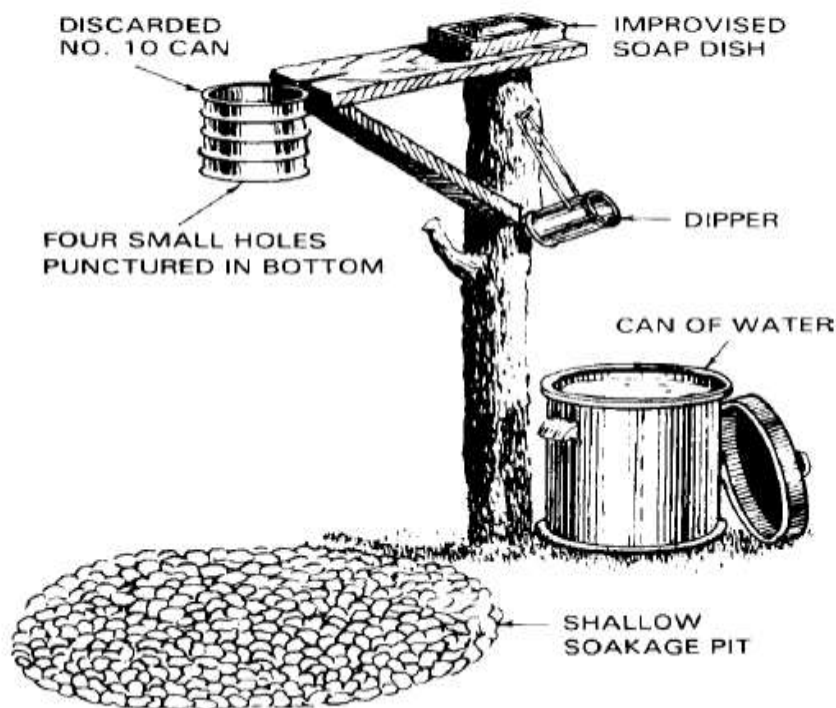


U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

www.cdc.gov/handwashing



Handwashing device—tipping 5-gallon cans.



Handwashing device.

Use a Sharps Container

- 1 Visually check sharps container for hazards before handling. Read all labels.

MAKE SURE
container is not overfilled
or damaged.

CHECK
that container is large
enough to fit your sharp.



- 2 Put sharp in container immediately after use.



Discard a Sharps Container

Stop using sharps container
when 2/3 full or
filled to FULL line.



- 1 Close sharps container as instructed on label.

Different containers have different closures.



- 2 Bring sharps container to a sharps disposal program.



Find a program through your local waste or public health department, your doctor, veterinarian, hospital or pharmacist.

TYPES OF SHARPS DISPOSAL PROGRAMS:



Mail-back program



Drop box or supervised collection site



Special waste pick-up service



At-home needle destruction device



Syringe exchange program (SEP)



Hazardous waste collection site

For information about rules and laws in your community, contact the Coalition for Safe Community Needle Disposal at 800.643.1643. For more information on sharps visit fda.gov/safesharpsdisposal or safeneedledisposal.org.

If You Cannot Get a Sharps Container...

FDA RECOMMENDS ALWAYS USING
FDA-CLEARED CONTAINERS

If you do not have a sharps container, use an empty household container with these features:



DO NOT USE

These containers can break or puncture easily.



Milk container



Soda can



Glass container



Water bottle

Dispose of a household sharps container when it is 2/3 full:

- 1 Close lid and tape shut. Label container.



- 2 Bring container to a sharps disposal program.

If you cannot find a disposal program, put container in center of full trash bag and discard in regular trash.*



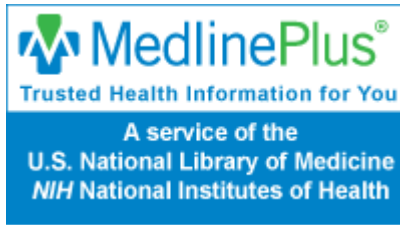
*In some areas it is illegal to dispose of sharps in the trash. Please follow your community guidelines.

ADVISOR

ADvanced Virtual Support for Operational Forces

1-833-ADVSRLN (1-833-238-7756 or DSN 312-429-9089)

The Department of Defense ADVISOR program provides global on-demand access to a full spectrum of medical tele-consultation services for emergent and urgent care, and it delivers those services 24/7/365 to the point of need in austere environments that have limited to no local specialty support. Field medical personnel anywhere in the world can call one phone number **1-833-ADVSRLN (1-833-238-7756 or DSN 312-429-9089)** and get immediate live help in 13 different medical specialties, from emergency care and critical care to infectious diseases and toxicology. With ADVISOR, field medics get real-time access to capabilities they otherwise lack and guidance on improvising care using whatever resources are at hand.



MedlinePlus is an online health information resource for patients and their families and friends. It is a service of the National Library of Medicine (NLM), the world's largest medical library, which is part of the National Institutes of Health (NIH). The mission of MedlinePlus is to present high-quality, relevant health and wellness information that is trusted, easy to understand, and free of advertising, in both English and Spanish. Anywhere, anytime, on any device—for free. (<https://medlineplus.gov/>)

TRAIN is a national learning network that provides thousands of quality training opportunities to more than 2 million professionals who protect and improve the public's health. Powered by the Public Health Foundation (PHF), the TRAIN Learning Network brings together agencies and organizations in the public health, healthcare, and preparedness sectors to disseminate, track, and share trainings for the health workforce on a centralized training platform. (<https://www.train.org/>)



Military Health System

Your health, our priority 24/7

1-800-TRICARE (1-800-874-2273)



**Veterans
Crisis Line**

DIAL 988 then PRESS 1

Know the Risk Factors

Risk factors are characteristics that make it more likely that someone will consider, attempt, or die by suicide. They can't cause or predict a suicide attempt, but they're important to be aware of.

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illnesses
- Previous suicide attempt(s)
- Family history of suicide
- Job or financial loss

988
SUICIDE
& CRISIS
LIFELINE

- Loss of relationship(s)
- Easy access to lethal means
- Local clusters of suicide
- Lack of social support and sense of isolation
- Stigma associated with asking for help
- Lack of healthcare, especially mental health and substance abuse treatment
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Exposure to others who have died by suicide (in real life or via the media and Internet)

Know the Warning Signs

Some warning signs may help you determine if a loved one is at risk for suicide, especially if the behavior is new, has increased, or seems related to a painful event, loss, or change. If you or someone you know exhibits any of these, seek help by calling the Lifeline.

- Talking about wanting to die or to kill themselves
- Looking for a way to kill themselves, like searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or isolating themselves
- Showing rage or talking about seeking revenge
- Extreme mood swings






NOTICE

THE JBLM ANTI-TERRORISM OFFICE (JBLMATO) MONITORS THIS LOCATION



A JBLMATO evidence technician processes evidence for finger-prints and trace DNA evidence. Results will be entered in the DoD Intelink database for potential identification match.

It is the mission of the Joint Base Lewis-McChord Anti-Terrorism office to gather and share intelligence with its partners to allow the dissemination of this information, collaborate across agencies, and conduct business.

This location is under surveillance due to the posting of "anti-DoD" themed flyers. It is possible these flyers were placed by individuals that may be Homegrown Violent Extremists (HVE) and could pose a threat to JBLM military and civilian personnel, and local citizens. It is this activity for which the JBLMATO is conducting surveillance in response.

All persons and vehicles entering or exiting this location may have unique identification aspects such as vehicle, license plate information, and general physical description documented.

See something? Say something!

Because of national and worldwide events in the post-9/11 era, it's up to all citizens to take an active part of their safety, and their community's safety by being cognizant of their surroundings - to have a "situational awareness".

Things that seem out of the ordinary *may* indeed be out of the ordinary. Many investigations reach a conclusion due to tips from local citizens that thought their contributions "may not mean anything" but were substantial pieces of actionable intelligence.

If you have any information on the individual(s) responsible for posting these flyers, send your tip, anonymously if desired, to JBLMATO@

Any and all information provided will be kept confidential, and is not subject to disclosure under FOIA requests, per 5 U.S.C. § 552(c)(2).

Government surveillance is not just about gathering evidence of criminal activity. **Surveillance is also a form of harassment and intimidation used against individuals in a malicious attempt to reduce the quality of their life** so they will: be intimidated into silence, have a nervous break-down, become institutionalized, experience constant mental, emotional, or physical pain, become homeless, or even commit suicide. These COINTELPRO tactics continue to this very day, putting targeted individuals and our communities at a whole at risk.

In her book, [Spying on Democracy](#), (City Lights Open Media, 2013) Heidi Boghosian, the former director of the National Lawyers' Guild, wrote about the Directorate of Emergency Services (DES) at Joint Base Lewis-McChord, WA saying that **JBLM aimed to neutralize political protest through a pattern of false arrests and detentions, attacks on homes and friendships, and attempting to impede community members from peacefully assembling and demonstrating anywhere, at any time. Harassment was systematic and pervasive.**

**POISON
HELP**

1-800-222-1222



The ability to communicate and make yourself understood can make a difference in life-threatening situations — imagine for example that you are trying to alert a search and rescue helicopter of the position of a downed pilot. To ensure clear communication, NATO uses a number of well-known formats which are in general use. NATO standardization agreements enable forces from many nations to communicate in a way that is understood by all.

Some standards can be found in everyday civilian and military life. "Bravo Zulu", typically signalled with naval flags on ships at sea and meaning "well done", is also commonly used in written communication by the military, for example: "Bravo Zulu 100000". For more on this, see http://www.military-terms.com/bravo_zulu.htm.

Numbers

									
China (one)	Two (one)	Three (one)	Four (one)	Five (one)	Six (one)	Seven (one)	Eight (one)	Nine (one)	Zero (one)
1	2	3	4	5	6	7	8	9	0

Phonetic alphabet

The NATO signal became effective in 1950 and a few years later, turned into the established universal phraseology for all military, civilian and amateur radio

International Morse Code

WATER TREATMENT AND USE

Flaghoist communication

Students use these as guides to send out messages to each other. The use of flags, known as *flagged communication*, is a fun and creative way to send information in daylight.

Semaphore

A



varied significantly

Parents are advised against sending anyone messages to an adult. Using a verified email, parents should send messages to police, for example to report the loss of a child.

B Bravo (bravo only) ... 	C Charlie (charlie only) ... 	D Delta (dell only) ... 	E Echo (eddy only) ... 	F Foxtrot (foks rost) ... 
G Golf (golf) ... 	H Hotel (hotel) ... 	I India (in-die only) ... 	J Juliett (jow-lee-et) ... 	K Kilo (key-lee) ... 
L Lima (lee-mah) ... 	M Mike (mike) ... 	N November (now-ven-ber) ... 	O Oscar (oss only) ... 	P Papa (pah-pah) ... 
Q Quebec (chek-kebek) ... 	R Romeo (row-ree-oh) ... 	S Sierra (see-ah only) ... 	T Tango (tang go) ... 	U Uniform (you-err-form) ... 
V Victor (vik only) ... 	W Whiskey (wicks-ey) ... 	X X-ray (eks-ep) ... 	Y Yankee (yang-ey) ... 	Z Zulu (zoo-luh) ... 

NOAA Weather Radio "All Hazards" Broadcasts

NWR broadcasts National Weather Service (NWS) warnings, watches, forecasts and other non-weather related hazard information 24 hours a day. Channels WX1-WX7 are used in the US & Canada; channels WX8-WX9 are used for Canada Marine Weather broadcasts in some areas. These channels should be programmed as wideband FM (16K0F3E) receive only. Some radio manufacturers number the US weather channels in the order they came into use, others number them in frequency order. For programming in land-mobile radios, frequency order is recommended.

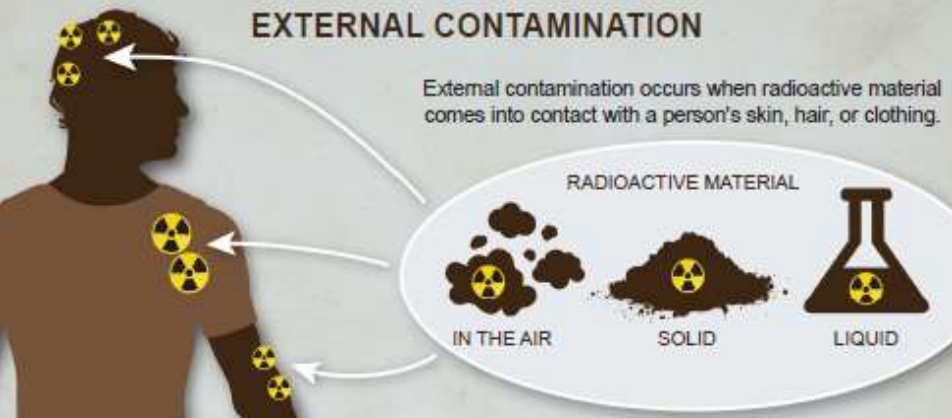
Weather Radio Broadcasts – Receive Only (WX1-WX7 US & Canada; WX8-WX9 Canada Marine Weather)

WX1	WX2	WX3	WX4	WX5	WX6	WX7
162.400	162.425	162.450	162.475	162.500	162.525	162.550

Marine 21B	Marine 83B
WX8	WX9
161.650	161.775

RADIATION CONTAMINATION VERSUS EXPOSURE

EXTERNAL CONTAMINATION

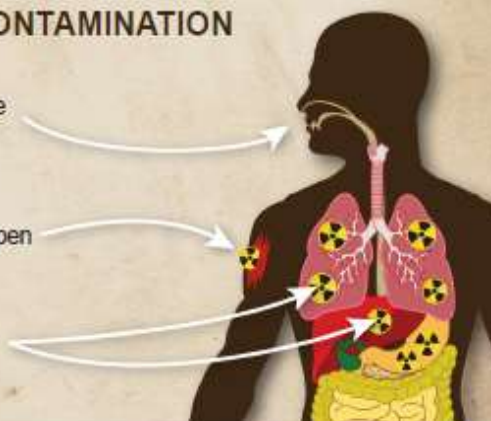


INTERNAL CONTAMINATION

External contamination can occur when radioactive material is swallowed or breathed in.

External contamination can also occur when radioactive material enters the body through an open wound.

Different radioactive materials can accumulate in different body organs.



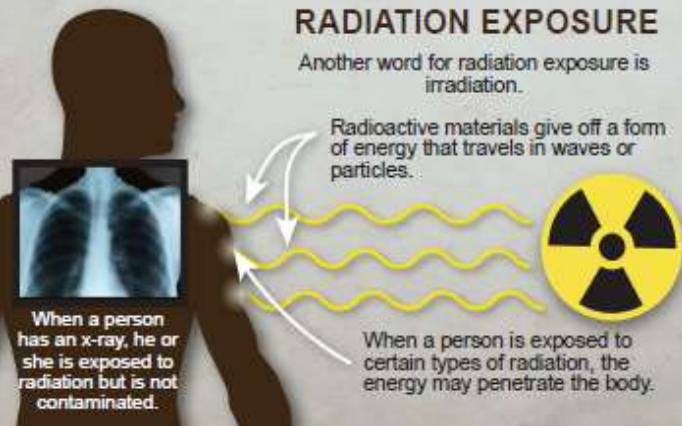
RADIATION EXPOSURE

Another word for radiation exposure is irradiation.

Radioactive materials give off a form of energy that travels in waves or particles.

A person exposed to radiation is not necessarily contaminated with radioactive material.

For a person to be contaminated, radioactive material must be on or inside of his or her body.



When a person has an x-ray, he or she is exposed to radiation but is not contaminated.

When a person is exposed to certain types of radiation, the energy may penetrate the body.



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

<http://emergency.cdc.gov/radiation>

DECONTAMINATION FOR YOURSELF AND OTHERS

① TAKE OFF OUTER LAYER OF CLOTHING



Taking off your outer layer of clothing can remove up to 90% of radioactive material.

Be very careful in removing your clothing to prevent radioactive dust from shaking loose.



Put the clothing in a plastic bag or other sealable container.

Put the bag in an out-of-the-way place, away from other people and pets.



② WASH YOURSELF OFF

If you can take a shower:

Use soap and shampoo. Do not use conditioner because it will cause radioactive material to stick to your hair.

Do not scald, scrub, or scratch your skin.

Keep cuts and scrapes covered when washing to keep from getting radioactive material in open wounds.



If you cannot take a shower:

Wash your hands, face, and parts of your body that were uncovered at a sink or faucet. Use soap and plenty of water.



If you cannot use a sink or faucet:

Use a moist wipe, clean wet cloth, or damp paper towel to wipe the parts of your body that were uncovered. Pay special attention to your hands and face.



Blow your nose and wipe your eyelids, eyelashes, and ears with a moist wipe, clean wet cloth, or damp paper towel.



③ PUT ON CLEAN CLOTHES

If you have clean clothes:

Clothes stored in a closet or drawer away from radioactive material are safe to wear.



If you do not have clean clothes:

Take off your outer layer of clothing, shake or brush off your clothes, and put your clothes back on.



Rewash your hands, face, and exposed skin at a sink or faucet.



④ HELP OTHERS AND PETS



Wear waterproof gloves and a dust mask if you can.

Keep cuts and scrapes covered when washing to keep radioactive material out of the wound.



Rewash your hands, face, and parts of your body that were uncovered at a sink or faucet.



WHERE TO GO IN A RADIATION EMERGENCY



GET INSIDE



STAY INSIDE



STAY TUNED

If a radiation emergency happens in your area, you should get inside immediately.

No matter where you are, the safest action to take is to: **GET INSIDE. STAY INSIDE. STAY TUNED.**

- Close and lock all windows and doors.
- Go to the basement or the middle of the building. Radioactive material settles on the outside of buildings; so the best thing to do is stay as far away from the walls and roof of the building as you can.
- If possible, turn off fans, air conditioners, and forced-air heating units that bring air in from the outside. Close fireplace dampers.
- Bring pets inside.
- Stay tuned for updated instructions from emergency response officials.

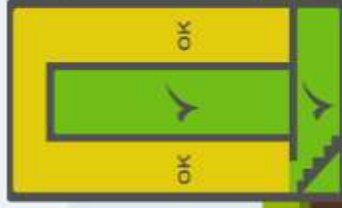


NOT SAFE

OK SAFER



SAFEST



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

<http://emergency.cdc.gov/radiation>

RADIATION EMERGENCIES AND PREGNANCY

After a radiation emergency, pregnant women should follow instructions from emergency officials and seek medical attention as soon as emergency officials say it is safe to do so.



Prenatal radiation exposure occurs when a pregnant woman's abdomen is exposed to radiation.

For most radiation exposures, the radiation dose to the fetus is lower than the dose to the woman. A pregnant woman's abdomen partially protects the fetus from radiation sources that are outside her body.

If a pregnant woman swallows or breathes in radioactive materials, these may be absorbed into her bloodstream. From the woman's blood, radioactive materials may pass through the umbilical cord to the fetus or concentrate in areas of the mother's body near the womb and expose the fetus to radiation.

Health effects to the fetus from radiation exposure can be severe, even at radiation doses too low to make the mother sick. These health effects can include miscarriage, stunted growth, deformities, abnormal brain function, and cancer.

A fetus is most sensitive to radiation between weeks 2 and 18 of pregnancy. A fetus will become less sensitive to radiation during later stages of pregnancy.

In the rare event of a radiation emergency, radiation experts can answer questions from pregnant women and their healthcare providers about radiation exposure and pregnancy.



U.S. Department of
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Centers for Disease
Control and Prevention

HOW POTASSIUM IODIDE (KI) WORKS

How does KI work?

The thyroid gland cannot tell the difference between non-radioactive and radioactive iodine. It will absorb both kinds.

KI works by keeping radioactive iodine out of the thyroid gland where it can cause damage. When a person takes KI, the thyroid absorbs the non-radioactive iodine in the medicine. Because KI contains so much non-radioactive iodine, the thyroid becomes "full" and cannot absorb any more iodine—either stable or radioactive—for the next 24 hours.

KI is a pill or liquid that can be used in radiation emergencies that involve radioactive iodine. KI contains non-radioactive iodine. Non-radioactive iodine helps prevent radioactive iodine from being absorbed by the thyroid gland.



Without KI



With KI



KI does not keep radioactive iodine from entering the body and cannot reverse the health effects caused by radioactive iodine once the thyroid gland is damaged.



Do not use table salt or food as a substitute for KI. Table salt and foods rich in iodine do not contain enough iodine to block radioactive iodine from getting into your thyroid gland. Too much table salt can be harmful.



Do not use dietary supplements that contain iodine in place of KI. Only use KI products that have been approved by the Food and Drug Administration (FDA).



Only take KI on the advice of a medical doctor, public health, or emergency management officials. Taking too much KI or taking KI when it is not recommended can have serious health risks.

For more information about KI dosage and side effects visit <http://emergency.cdc.gov/radiation>



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HOW PRUSSIAN BLUE WORKS

Prussian blue is a pill that may be used in a radiation emergency to help remove radioactive cesium (Cs) and thallium (Tl) from inside a person's body.



Prussian blue traps radioactive cesium and thallium in the intestines and keeps them from being reabsorbed by the body.



The radioactive materials then move through the intestines and are passed (excreted) in bowel movements.

Because Prussian blue reduces the time that radioactive cesium and thallium stay in the body, it helps limit the amount of time the body is exposed to radiation.

Prussian blue is available only by prescription. Public health and medical professionals will determine if Prussian blue is needed.

People **SHOULD NOT** take Prussian blue artist's dye in an attempt to treat themselves. This type of Prussian blue is not designed to treat radioactive contamination and can be harmful.



U.S. Department of
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Control and Prevention

<http://emergency.cdc.gov/radiation>

DEFENDING AGAINST TEAR GAS

THE FOLLOWING TIPS ARE TO BE EXERCISED **ONLY FOR DEFENSE PURPOSES** AND IN THE EVENT OF POLICE/GOVERNMENT OFFICIALS USING TEAR GAS IN PEACEFUL PROTESTS. **NEVER INCITE VIOLENCE.**

ITEMS YOU WILL NEED

PAINTERS/DUST MASK
FOUND IN HARDWARE STORES



EYE PROTECTION
FOUND IN HARDWARE STORES



WATER SPRAY BOTTLE
MAKE SURE WASHED OF ANY
CLEANING SOLUTION



LIQUID ANTACID
ANY IN LIQUID FORM SUCH
AS MAALOX OR MYLANTA



HELPING YOURSELF AND OTHERS

- AFTER USING THE LIQUID ANTACID AND WATER METHOD ON YOURSELF, HOLD UP YOUR SPRAY BOTTLE AND START SHOUTING FOR PEOPLE TO COME TOWARDS YOUR VOICE FOR HELP. SPRAY THEIR FACE AND MOUTH.
- IF YOU ARE WEARING EYE PROTECTION OR A MASK, BE PROACTIVE AND KICK THE CANISTER AWAY FROM THE CROWD. IF YOU CAN KICK IT DOWN A GUTTER, OR DOUSE IT WITH WATER, YOU CAN MINIMIZE ITS IMPACT.
- STAY PEACEFUL. PEACEFUL PROTEST IS THE ONLY WAY TO BE TAKEN SERIOUSLY AND TO BE TRULY HEARD.

KNOW YOUR ENEMY

TEAR GAS IS A NON-LETHAL CHEMICAL WEAPON THAT **STIMULATES THE CORNEAL NERVES IN THE EYES TO CAUSE TEARING, PAIN, AND EVEN BLINDNESS.** TEAR GAS WORKS BY IRRITATING MUCOUS MEMBRANES IN THE EYES, NOSE, MOUTH AND LUNGS, AND CAUSES CRYING, SNEEZING, COUGHING, DIFFICULTY BREATHING, PAIN IN THE EYES, TEMPORARY BLINDNESS, ETC.

TEAR GAS RELIEF

Liquid Antacid and Water (LAW)

BE PREPARED FOR EXPOSURE. TEAR GAS IS A PARTICULATE, NOT REAL GAS, SO PAINTERS/DUST MASKS HELP.

"GREEKS HAVE BECOME SKILLED AT CHOOSING THE RIGHT PROTECTIVE GEAR. MAALOX IS A MUST."

ARIS MESSINIS/AFP

- 1) FIND A GOOD SIZE SPRAY BOTTLE AND WASH WELL.**
- 2) FILL HALF OF SPRAY BOTTLE WITH LIQUID ANTACID (MAALOX).**
- 3) FILL THE REMAINING HALF OF BOTTLE WITH WATER.**
- 4) WHEN EXPOSED SPRAY YOUR EYES AND MOUTH, THEN SWALLOW.**

ALSO EFFECTIVE AS PEPPER SPRAY REMEDY

A UNIVERSITY OF CALIFORNIA SAN FRANCISCO-BASED STUDY HAS FOUND THAT TOPICAL APPLICATION OF ANTACIDS "FOR CAPSAICIN-INDUCED PAIN IS EFFECTIVE, PARTICULARLY IN EARLY TREATMENT OF EXPOSURE TO REFINED CAPSAICIN."



deptofunitedwerise@hotmail.com

STAY VIGILANT. STAY UNITED. STAY INFORMED. PROTECT YOUR FELLOW COUNTRYMEN. DO NOT TRUST THE MEDIA.

SOURCES:

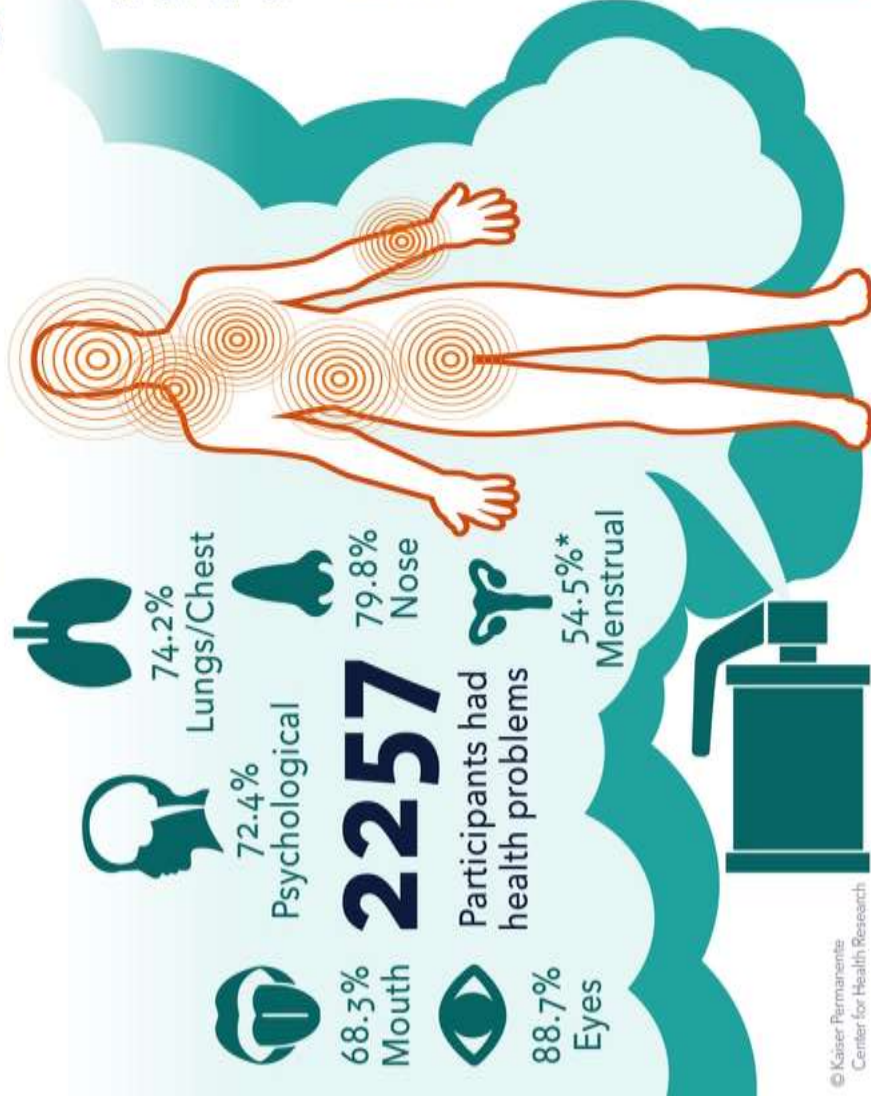
@JasonPicard

GLOBAL POST: <http://www.globalpost.com/dispatches/news/regions/europe/protestor-chic-how-greeks-prepare-tear-gas>

Wikia (Medic Wiki): http://medic.wikia.com/wiki/Pepper_spray_and_tear_gas

WIKIPEDIA: http://en.wikipedia.org/wiki/Tear_gas

Health effects associated with tear gas exposure



33% 18-33 years old

51% Female

28% BIPOC

93% Exposed at protest

54.6%

Used or intended
to use healthcare



MAKESHIFT TEAR-GAS MASK



1 Use the permanent marker to draw a U-shaped area big enough to fit your face.



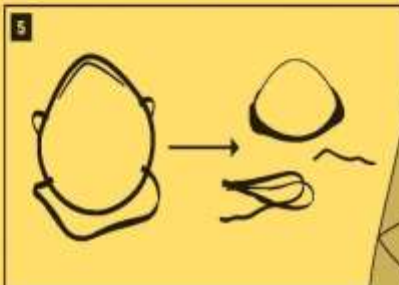
2 Cut away the bottom of the bottle just above the ridged area and discard it.



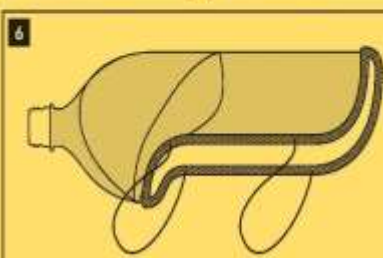
3 Cut along the lines of the template to remove the U-shaped section.



4 Use a single length of foam insulation to fold over the edges of the bottle until it is completely covered.



5 Remove the two elastic bands and metal bridge from the surgical mask. Set the elastic bands aside and discard the metal bridge. Push the mask down into the neck of the bottle.



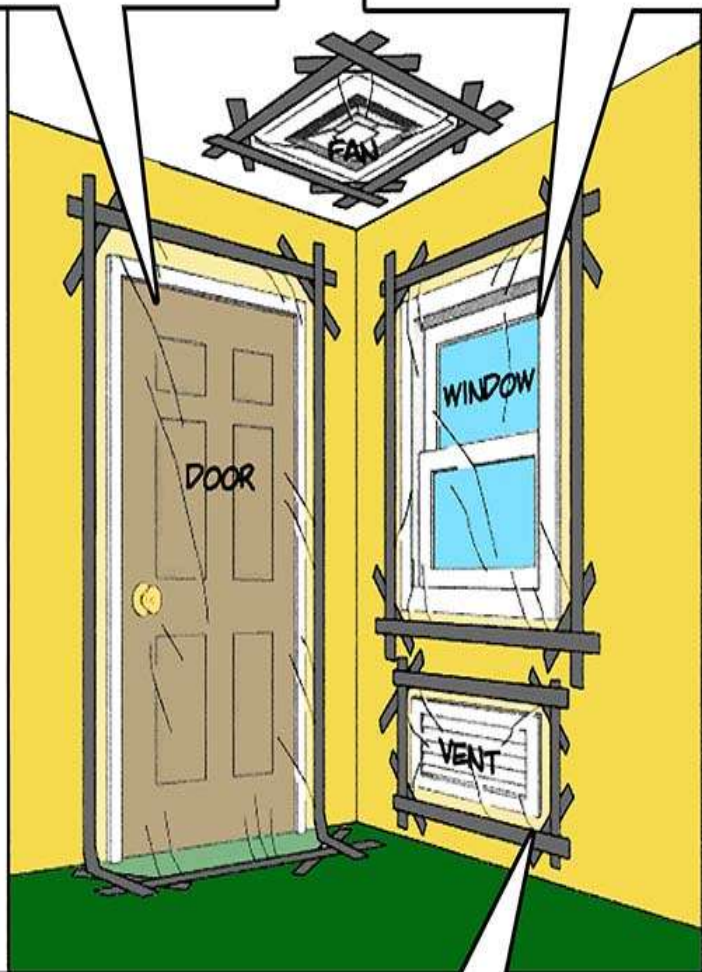
6 Make four small holes in the sides of the mask. Feed the ends of the elastic bands through the holes and tie them off so they can be pulled back through. Seal the holes with glue to prevent leaks in the mask. Carry a bottle of vinegar to soak the mouth cover before putting on the mask.



Cover all doors, windows and vents with 4 to 6 mil. thick plastic sheeting

Cut the plastic sheeting several inches wider than the openings and label each sheet

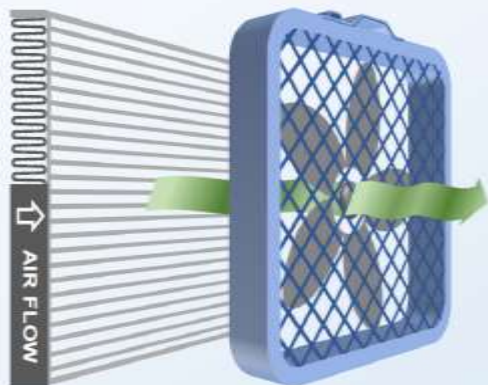
Ten square feet of floor space per person will provide sufficient air to prevent carbon dioxide build-up for up to five hours, assuming a normal breathing rate while resting.



Duct tape plastic at corners first, then tape down all edges

DIY Air Cleaner to Reduce Wildfire Smoke Indoors

Materials



20" X 20" air filter

20" X 20" box fan

Suggested rating: MERV 13

Only use certified fans with UL or ETL marking (2012 model or newer)



Clamps

or



Duct Tape

or



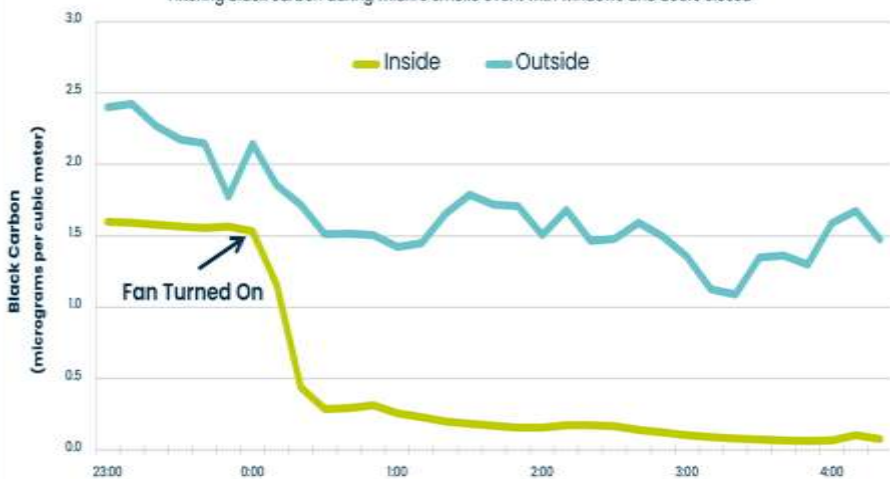
Bungee Cords

Assembly

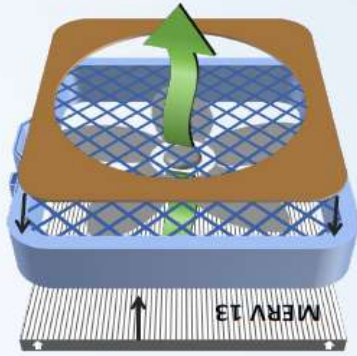
1. Attach the air filter to the back of the box fan using either clamps, duct tape or bungee cords.
2. Check the filter for the direction of the air flow (marked on the side of the filter).
3. Replace filters when dirty.

Filter Fan Performance

Filtering black carbon during wildfire smoke event with windows and doors closed



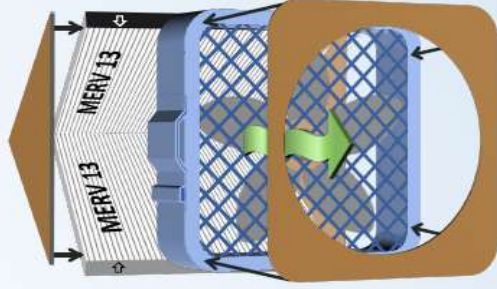
DIY Air Cleaner Designs: Beyond the Basic



Good

Basic Supplies:

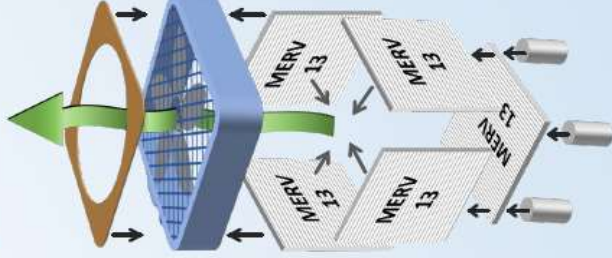
- 20" x 20" box fan
- 20" x 20" x 1" or 4" MERV 13 air filter
- 20" x 20" cardboard shroud (cutout the size of the fan blades)
- Clamps, duct tape, or bungee cords



Better

Additional Supplies:

- Two - MERV 13 air filters
- Triangle cardboard cutout for base on top



Best

Additional Supplies:

- Four or five - MERV 13 air filters
- If using five filter design, use leg supports (e.g., blocks) to allow airflow through bottom

Ways to Improve

Effectiveness:

- Add a cardboard shroud (no-cost improvement)
- Use thicker filters (4" rather than 1" MERV 13 filters)
- Use multiple filters (2-5 filter designs)

Key Reminders:

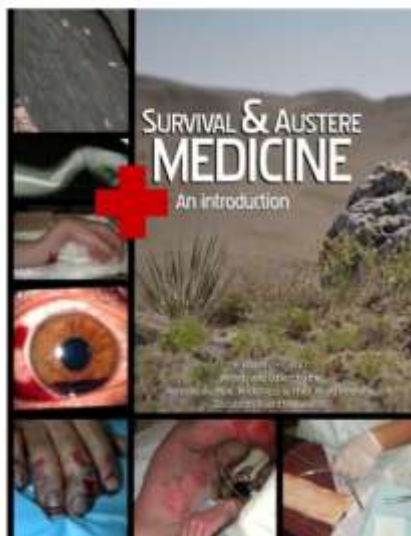
- Only use certified fans with UL or ETL marking (2012 model or newer)
- Keep extra filters on hand
- Replace filters when dirty

Online First Aid & Medical Training



The **Global First Aid Reference Centre** is a 'centre of excellence' of the International Federation of Red Cross and Red Crescent Societies (IFRC) hosted by the French Red Cross. The European Centre for First Aid Education was created in 1996 then became Global First Aid Reference Centre (GFARC) in 2012 to answer growing demands in our field. Our ultimate objectives are to reduce the number of deaths and the severity of injuries as well as to make people and communities more resilient using first aid.

[\(https://www.globalfirstaidcentre.org/\)](https://www.globalfirstaidcentre.org/)



In 2017, the Remote, Austere, Wilderness & Third World Medicine discussion board moderators released the 3rd Edition of **Survival and Austere Medicine**. The 3rd Edition grew to over 600 pages compared to the 2nd Edition's 200+ pages. Survival and Austere Medicine work may be copied

and distributed freely if the entire text and all disclaimers and copyright notices remain intact. You can download a copy here: (<https://bit.ly/3vS9mmB>)

Special Operations Individual Medical Equipment, Part I - The Major Trauma Kit (<https://bit.ly/3LiweC5>)

Special Operations Individual Medical Equipment, Part II - The In-Use and Survival Medical Kits (<https://bit.ly/3rVZo2f>)

Unlike the information extracted from other military references, the articles in the Journal of Special Operations Medicine (JSOM) are copyrighted.

Because of the copyright on the articles, we have not reproduced them here, but they are available on the JSOM web-site at the URLs listed above, and are recommended reading.

Basic Emergency Care - Developed by the World Health Organization and International Committee for the Red Cross (ICRC), in collaboration with the International Federation for Emergency Medicine (IFEM), the *Basic Emergency Care (BEC): Approach to the Acutely Ill and Injured course is an open-access training course for first contact health workers who manage acute illness and injury with limited resources. Course Length: Approximately 7 hours (<https://openwho.org/courses/bec>)

- Module 1: The ABCDE and SAMPLE history approach
- Module 2: Trauma
- Module 3: Difficulty in Breathing
- Module 4: Shock
- Module 5: Altered Mental Status
- Module 6: Transfer and Handover

Basic Emergency Care: Conflict-Related Injuries - Developed by the World Health Organization, International Committee of the Red Cross and the International Federation for Emergency Medicine, the BEC Extended Modules: Conflict-Related Injuries support the delivery of quality emergency care for patients with conflict-related trauma, covering penetrating injury, blast injury and burns. These extended modules follow the BEC systematic approach to the initial assessment and management of time-sensitive critical conditions where early intervention saves lives. (<https://openwho.org/courses/bec-conflict-related-injury>)

Deployed Medicine is a platform used by the Defense Health Agency to trial new innovative learning models aimed at improving readiness and performance of deployed military medical personnel. The intent is to deliver personalized, dynamic learning using the most current and accessible technology, enabling a self-directed and continuous study of medical best practices and lessons learned. (<https://www.deployedmedicine.com/>)

Disaster Ready launched in 2013 with a simple but powerful mission: To better prepare humanitarian and development professionals for the critical work they do by providing high-quality, relevant online learning resources at no cost. The entire catalog of over 1,500 courses, videos, reference documents, and assessment-based certificate and certification programs are available on demand and 100% free. (<https://www.disasterready.org/>)

General Backcountry Safety - This is a free, online course designed to provide an introduction for beginners and intermediate backcountry enthusiasts to help develop safe habits in the backcountry. This material is designed to cover the fundamental ideas that will help equip you to travel safely and be able to deal with emergency situations that can occur in the backcountry. (<https://training.mra.org/course/index.php?categoryid=2>)

International Federation of Red Cross and Red Crescent Societies (IFRC) offers a wealth of learning opportunities and resources to our National Societies, volunteers, partners and the general public. (<https://www.ifrc.org/get-involved/learn-us>)

National Center for Biomedical Research and Training offers a number of 'Micro Modules' that provide information on responding to conflict-related injuries. (<https://moodle.ncbrt.lsu.edu/>)

NextGenU provides free health science certificate courses to learners in every country through over 1,200 institutions. NextGenU has long been recognized for their free online public health courses, but they have recently made an even bigger step – offering the first entirely FREE online MPH degree, developed in partnership with the WHO, the CDC, and many other organizations. (<https://nextgenu.org/>)

Psychological First Aid (PFA) Online is a 5-hour interactive online course that helps participants learn the core actions of PFA and describes ways to apply them in different post-disaster scenarios and with different survivor needs. This course also covers provider well-being before, during, and after disasters. This course is relevant for new providers who are wanting to be oriented to PFA, as well as for seasoned practitioners who want a review of the PFA concepts. (<https://www.samhsa.gov/resource/dbhis/psychological-first-aid-online>)

Stop The Bleed Interactive Course - The interactive course is a virtual alternative to the in-person lecture presentation. The course guides individuals through the three methods of bleeding control using video demonstrations, interactive learning, and spontaneous quizzes. This Stop The Bleed Interactive Course is free to all students and can be taken multiple times to learn and refresh knowledge of the Stop The Bleed.

(<https://www.stopthebleed.org/training/online-course/>)

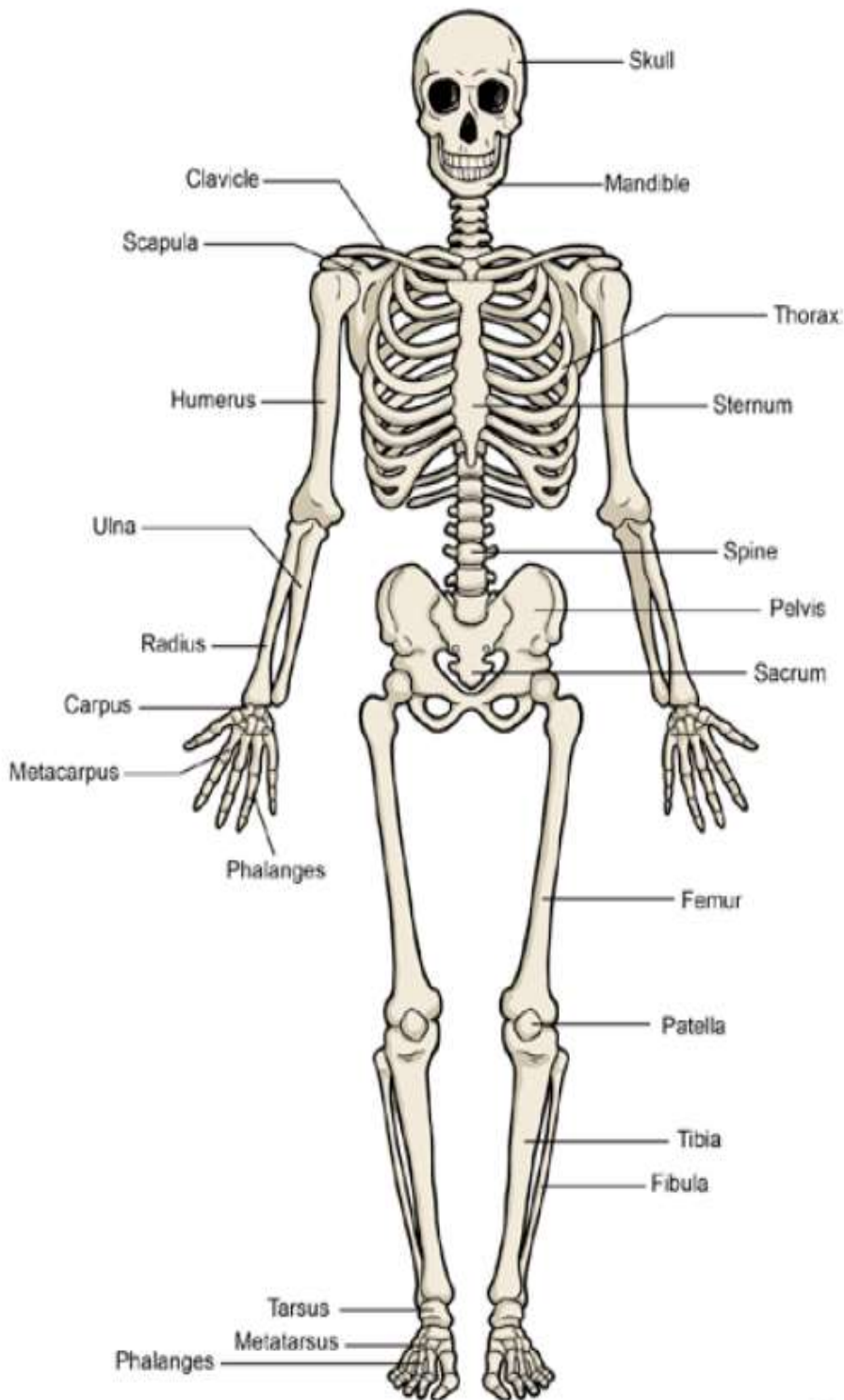
University of Hawaii at Mānoa's Pacific Emergency Management, Preparedness, and Response Information Network and Training Services (Pacific EMPRINTS) offers online courses to help healthcare professionals to better recognize and respond to chemical, biological, radiological, nuclear and explosive events and to other large-scale public health emergencies.

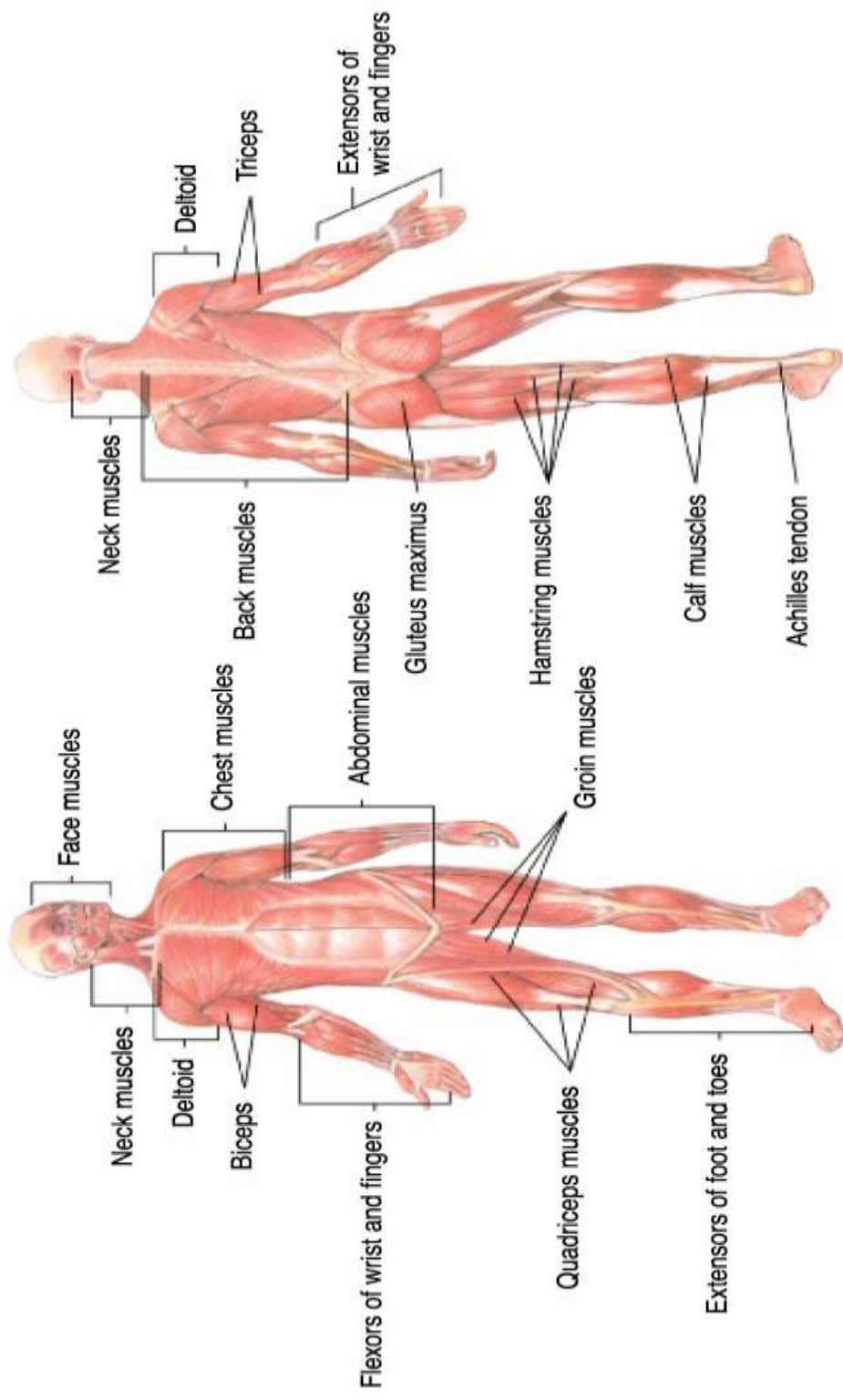
(<https://iph.sdsu.edu/courses/online.php>)

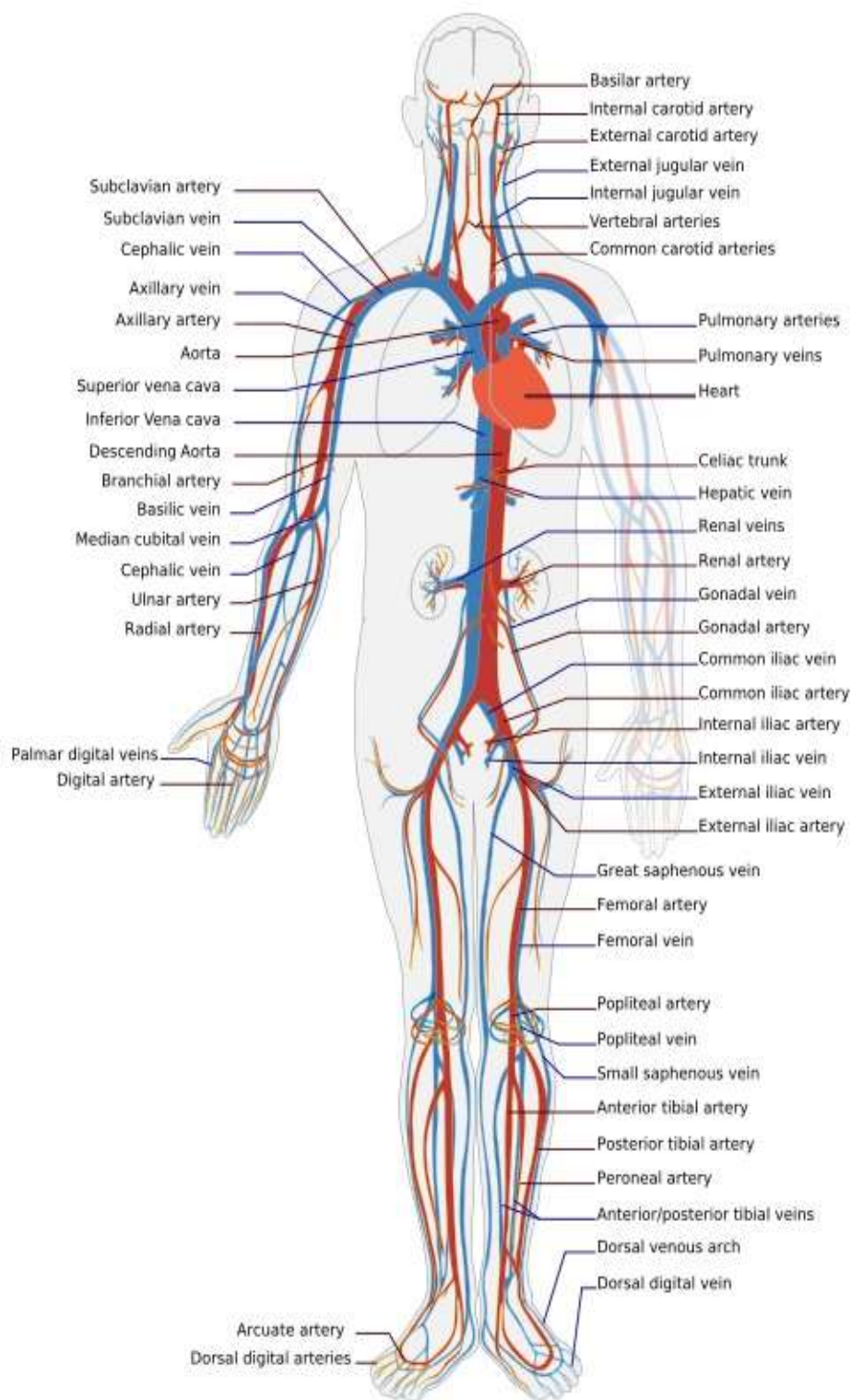
University of Utah – Advanced Wilderness Life Support (AWLS) is one of the most respected certificates in wilderness medicine. It is for all medical professionals, including physicians, nurses, nurse practitioners, dentists, physicians' assistants, EMT's, paramedics, podiatrists, and veterinarians. Course material is available for free. There is a small exam fee if you want to receive a certificate.

(<https://www.awls.online/>)

World Health Organization (WHO) free open-access platform servicing frontline responders, health workers, policymakers and anyone interested in learning about public health. (<https://openwho.org/>)









TACTICAL COMBAT CASUALTY CARE (TCCC / TC3)



CoTCCC RECOMMENDED DEVICES & ADJUNCTS AS OF: 01 AUG 2019

In accordance with
CoTCCC Guidelines

TOURNIQUETS, LIMB NON-PNEUMATIC

Common Name / Brand Name

Combat Application Tourniquet (CAT) Gen 7
Combat Application Tourniquet (CAT) Gen 6
Ratcheting Medical Tourniquet (RMT) Tactical
SAM Extremity Tourniquet (SAM-XT)
SOF-Tactical Tourniquet-Wide (SOFTT-W)
Tactical Mechanical Tourniquet (TMT)
TX2 Tourniquet (TX2)
TX3 Tourniquet (TX3)

DLA Nomenclature

Tourniquet Nonpneumatic Combat Application One-Handed 37.5" LG 1
Tourniquet Nonpneumatic Combat Application One-Handed 37.5" LG 1
Tourniquet, One Handed Burke Device Tactical
Tourniquet Nonpneumatic 25S
Tourniquet Nonpneumatic Nylon Strap 1.5" Wide Nylon Strap for Br
Tourniquet Nonpneumatic Tactical Mechanical Tourniquet
Tourniquet Nonpneumatic TX2 Ratcheting One-Hand Coyote
Tourniquet Nonpneumatic TX3 Ratcheting OD Green One Hand

NSN

6515-01-521-7976
Until Replaced by Gen7
6515-01-527-3841
6515-01-670-2240
6515-01-587-9943
6515-01-656-6191
6515-01-667-6027
6515-01-667-6208

(Alphabetical)

TOURNIQUETS, LIMB PNEUMATIC

Common Name / Brand Name

Emergency Medical Tourniquet (EMT)
Tactical Pneumatic Tourniquet 2" (TPT2)

DLA Nomenclature

Tourniquet Pneumatic Single-hand application fits upper and lower
Tourniquet Pneumatic Slide Fastener

NSN

6515-01-580-1645
6515-01-656-4831

HEMOSTATIC DRESSINGS/DEVICES

Common Name / Brand Name

Combat Gauze (CG) Z-Fold
Celox Gauze, Z-fold 5'
ChitoGauze
X-Stat, Single Applicator
iTCamp

DLA Nomenclature

Bandage Gauze Impregnated 3" W X 4 YDS L Kaolin Hemostatic Quik
Dressing Hemostatic Celox Gauze 3"X5' Z-folded
Dressing Hemostatic 144" length 3" width coated with Chitosan
Applicator Hemostatic Sponges and Dispenser Xstat-30 Each
Clamp Hemorrhage Control Sterile Medical Grade Polycarbonate

NSN

6510-01-562-3325
6510-01-623-9910
6510-01-591-7740
6510-01-644-7335
6515-01-629-7044

JUNCTIONAL TOURNIQUETS & DEVICES

Common Name / Brand Name

Combat-Ready Clamp (CROc)
SAM Junctional Tourniquet (SAM-JT)
Junctional Emergency Treatment Tool (JETT)

DLA Nomenclature

Clamp Tourniquet Expandable Aluminum Clamp/Collapsible/Lightwe
Tourniquet Kit Junctional Compression Inflatable 6 Piece
Tourniquet Inguinal Hemorrhage Adjustable 56.750" LG

NSN

6515-01-589-9135
6515-01-618-7475
6515-01-616-5841

AIRWAY MANAGEMENT DEVICES & ADJUNCTS

Common Name / Brand Name

Control Cric / CricKey
I-Gel Extraglottic Airway Sz 4
I-Gel Extraglottic Airway Sz 5 (>90kg)

DLA Nomenclature

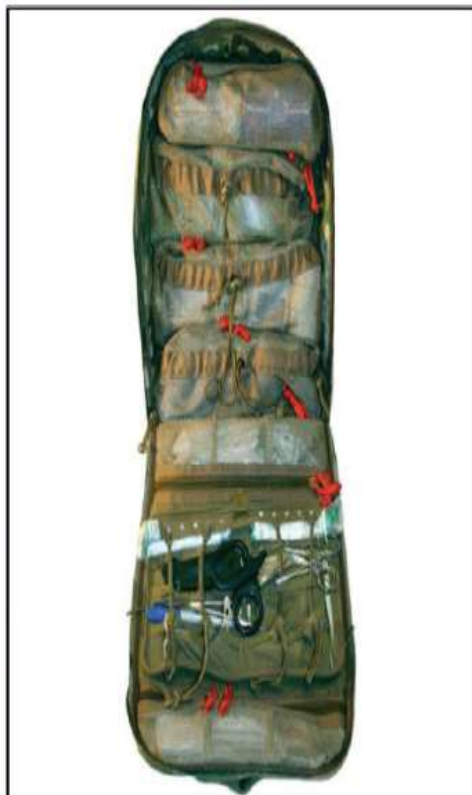
Cricothyrotomy System Verifies Tracheal Location during a Surg
Airway Supraglottic Sz 4/Med Adult Single-Use
Airway Supraglottic Sz 5/Large Adult Single-Use

NSN

6515-01-640-6701
6515-01-669-8680
6515-01-669-8725



M9 Medical Aid Bag



M9 Medical Aid Bag interior

M9 Medical Aid Bag contents

National Stock No.	Item	No. Per Kit
6545-01-572-9964	Medical Equipment Set (MES) Combat Medic	1
4240-01-568-3219	Strap Cutter, Combat	1
6510-00-926-8884	Surgical Adhesive Tape	1
6510-00-935-5823	Elastic Bandage, 6 inch by 4.5 yards	4
6510-01-492-2275	Bandage Kit, Elastic	4
6510-01-503-2117	Bandage Gauze, 4.1 yards.	4
6510-01-519-8421	Occlusive Dressings, 5s	1
6510-01-519-9253	Surgical Sponges, 40s	1
6510-01-532-8930	Bandage, Elastic, 16 by 12 inches	1
6510-01-562-3325	Bandage Gauze, Impregnated	6
6510-01-571-9729	Compress and Bandage	2

M9 Medical Aid Bag contents (continued)

National Stock No.	Item	No. Per Kit
6510-01-573-0300	Chest Seal Dressing	4
6510-01-587-6579	Burn First Dressing	2
6515-00-9357138	Bandage Scissors	1
6515-01-314-6694	Stethoscope Comb, 28 inch	1
6515-01-449-1016	Rigid Eye Shield, Fox12	4
6515-01-494-1951	Universal Splint	2
6515-01-515-0151	Tool Kit Rescue Oropharyngeal Airway	1
6515-01-5162554	Easy Fit Suction Kit	1
6515-01-5163120	Easy Suction Catheter	1
6515-01-519-6764	Surgical Drainage Tubes, 6s	1
6515-01-521-3082	Pharyngeal Airway, 2s	2
6515-01-521-5730	Leg Splint	1
6515-01-5217976	Non-Pneumatic Tourniquet	6
6515-01-527-8068	Medical Head Lamp	1
6515-01-529-1187	Nasal Trumpet	3
6515-01-536-9363	Intraosseous Infusion	2
6515-01-540-7226	Trauma Leash Shears	2
6515-01-541-0635	Needle Decompression	2
6515-01-557-1136	Oximeter Pulse Port	1
6515-01-573-0692	Cricothyrotomy Set	2
6515-01-593-4841	Resuscitator, Hand Open	1
6532-01-524-6932	Survival Blanket	1
6532-01-525-4062	Heating Blankets, 8s	1
6545-01-539-6450	Medical Aid Bag	1
7520-00-312-6124	Marker, Tube Type	1
8345-01-573-3304	Panel Marker	1

Common Medical Abbreviations

1°	Primary, First degree	N&V	Nausea & Vomiting
2°	Secondary, Second degree	NAD	No Acute/Apparent Distress
≈	Approximately equal to	NPO	Nothing By Mouth (per os)
A	Before (ante)	NKA	No Known Allergies
Abd	Abdomen	NKDA	No Known Drug Allergies
APE	Acute Pulmonary Edema	NTG	Nitroglycerin
BID	Twice daily	NYD	Not Yet Diagnosed
BP	Blood Pressure	P	After (post)
BSA	Body Surface Area	PE	Pulmonary Embolism
C	With	PR	Per Rectum
CA	Cancer	prn	As needed
CC	Chief Complaint	Q	Every
C/O	Complaining Of	q hr	Every Hour
CHF	Congestive Heart Failure	q2 hr	Every 2 Hours
CVA	Cerebrovascular Accident; Costo-Vertebral Angle	QID	4 Times A Day
Cx	Chest	Rx	Prescribed for
D ₁₀ W	Dextrose 10% Water	S	Without
Dx	Diagnosis	SC	Subcutaneous
D/C	Discontinue	s/p	Status Post
ED	Erectile Dysfunction	S/S	Signs and Symptoms
EP	Emergency Physician	SL	Sublingual
ET	Endotracheal	Sx	Seizure
ETOH	Alcohol	SOB	Shortness Of Breath
FAST	Face, Arm, Speech test	TID	Three Times A Day
Fx	Fracture	T	Temperature
Gtt	Drop	Tx	Transport; Treatment
GU	Genitourinary	UO	Urinary Output
H/A	Headache	U/S	Ultra Sound
H&PE	History and Physical Exam	VS	Vital Signs
HTN	Hypertension	WOB	Work of Breathing
Hx	History	YOA	Years Of Age
IN	Intra-Nasal	↓	Decreased
IO	Intra-Osseus	↑	Increased
JVD	Jugular Venous Distension	∅	No; None; Null
LOC	Level of Consciousness	ψ	Psych
MDI	Metered Dose Inhaler	♀	Female
MI	Myocardial Infarction	♂	Male
MOA	Months Of Age		

**IMPORTANT
NUMBERS OR
INFORMATION**

Police: _____ Dial 911 or #: _____

Fire: _____ Dial 911 or #: _____

Poison Control: _____ #: _____

Doctor: _____ #: _____

Doctor: _____ #: _____

Pediatrician: _____ #: _____

Dentist: _____ #: _____

Hospital/Clinic: _____ #: _____

Pharmacy: _____ #: _____

Medical Insurance: _____ #: _____

Policy #: _____

Medical Insurance: _____ #: _____

Policy #: _____

Homeowner/Rental Insurance: _____

#: _____

Policy #: _____

Flood Insurance: _____ #: _____

Policy #: _____

Veterinarian: _____ #: _____

Kennel: _____ #: _____

Electric Company: _____ #: _____

Gas Company: _____ #: _____

Water Company: _____ #: _____

Alternate/Accessible Transportation: _____

#: _____

Other: _____ #: _____

Other: _____ #: _____



Centers for Disease Control & Prevention
(<https://www.cdc.gov/>)

Defense Health Agency - Deployed Medicine
(<https://deployedmedicine.com/>)

International Federation of Red Cross and Red Crescent Societies (IFRC) (<https://www.ifrc.org/>)

Johanniter International (<https://johanniter.org/>)

National Institutes of Health (<https://www.nih.gov/>)

National Library of Medicine
(<https://www.nlm.nih.gov/>)

Prolonged Field Care Collective
(<https://prolongedfieldcare.org/>)

Wilderness Medical Society (<https://wms.org/>)

World Health Organization (WHO)
(<https://www.who.int/>)

